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PSYCHOANALYSIS AND BRIEF PSYCHOTHERAPY

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THE SEARCH FOR A FORMULA

As is well known, the average psychoanalytic treatment conducted on the basis of daily sessions, consumes between one and three years; but treatments of five and even more years duration are by no means exceptional. Although shortening of the treatment appears desirable from more than one standpoint, it is as if the psychoanalysts did not consider it practicable. To them, long treatments represent the only kind of treatments conforming to the rules, and they are inclined to consider abbreviated methods as incomplete, superficial, or simply non-analytical. This is regrettable for two reasons; first, psychoanalysis, which for a long time developed along investigative lines rather than therapeutic, left a good deal to be desired with regard to its curative results,* and secondly, public reaction to failures following short treatments is not so strong as to those following treatments which have consumed years of prodigious effort.

Some analysts attempted to improve this situation by developing new theories in the hope that a better theoretical understanding of the mechanisms involved would increase the therapeutic success. Ferenczi[7] tried to render the psychoanalytical method more "active" by a daring speculation on transference and regression; Rado[32] speaking about results stated as follows: "The somewhat capricious therapeutic results of psychoanalysis have forced us to revise our views on the pathology of neuroses." Hardly any attempt was made to effect changes in the original technique of psychoanalysis so as to improve the results.

* Statistics, so far available, bear this out; their inexactness and incompleteness is understandable. See Eitingon,[5] Glover,[12] Jameison and McNeil, [20] Kessel and Hyman,[21] Knight,[24] Oberndorf,[30] Wilder,[40] *et al.*

Years ago, a great deal of emotional antagonism usually arose when the question of changing the psychoanalytical technique was brought up.* It appeared as if psychoanalysis had reached the peak of its perfection. When patients who were rehabilitated or improved by a reformed psychoanalytical technique were cited or demonstrated, critics would invariably say that the results were due to the personality of the therapist or to transference, but that the procedure in question had nothing to do with psychoanalysis. For a "psychoanalysis" that does not follow the rules of the standard technique and does not last a few years, *is no psychoanalysis.*

Although the length of the psychoanalytical procedure and the rigidity of its technique were considered a major handicap by many psychoanalysts in the early days of the psychoanalytic movement, as well as to-day, attempts toward a reform of the cumbersome orthodox technique came only from "renegades" and "outsiders." We may mention here the works of Stekel,[39] W. Reich,[34] Hornay,[18] and Rank,[33] and the experiments with narco-analysis,[19] hypno-analysis[27] and group-analysis.[35]

Stekel[39] demanded that every new case should be considered as a psychiatric and therapeutic novum capable of overthrowing all existing views. And at a recent meeting devoted to the discusson of "brief psychotherapy"[4] Alexander complained that many psychotherapists use the same technique in all their cases, selecting the cases on the basis of their technique rather than attempting to modify the technique to fit their cases. According to him the detrimental results of this attitude are to be found in the fact that many cases are treated by a prolonged technique of psychoanalysis that might be helped by briefer methods, and that the rigidity in technique and thinking hampers the free development of psychotherapy. Alexander believes that if the principle of flexibility in technique were generally adopted, psychoanalysts would not adhere strictly to a rule regulating the number of interviews and would not continue the treatment uninterruptedly over long periods.

In the past years several factors have been advanced to explain the drawbacks of the orthodox analytical procedure. Masserman,[29] for example, maintains that psychoanalysts who use a special technique to study human behavior apply the same technique also as a therapeutic procedure. He calls this approach time-consuming, expensive and, in

* One of the critics called the author's work deprecatingly a "hobby of abbreviating psychoanalysis."

many cases, unnecessary. According to Alexander,[2] cases where the therapeutic and investigative aims fully coincide represent a minority; "In the majority there is a varying discrepancy between these two objectives." He goes so far as to say that the application of the classical technique of psychoanalysis is justified only in those cases where these two aims coincide, while in all other cases, therapeutic considerations may necessitate a deviation from the orthodox technique. In some cases the application of the orthodox technique may even prove dangerous; it may be a psychic onus to which a patient may react not only with transitory, but even permanent deterioration. Similarly, Oberndorf states that in some cases too persistent and too thorough a preoccupation with the unconscious may keep alive the inner strife in the patient's personality and may retard "those synthetic processes which make for ego integrity."

The views presented here, particularly the new currents emanating from the group around Alexander, come very close to those expounded many years ago by Stekel and his school. [37 38 14 16] It was Stekel who first warned that an artificial psychoanalytical introversion lasting for several years may lead to undesirable complications of the existing neurosis, and that it may even replace it by a "psychoanalytical" neurosis, which may be harder to handle than the original one.

While in his days Stekel's views met with a unanimous rebuff by the orthodox school, today the trends toward relaxation of the orthodox routine can no longer be overlooked. A change is gradually taking place which deserves attention. This change is by no means unopposed. As matters stand at the moment, the new movement will have to do away with a great deal of resistance among the dogmaticists of psychoanalysis before it will find a general recognition. Many terminological as well as technical differences will have to be clarified. One of the criticisms of the new trends is the same that was mentioned at the beginning: the method that uses a different technique is no psychoanalysis. In conformity with this view, the majority of the speakers at the Brief Psychotherapy Council in a tenacious adherence to the old standards, refused to identify any briefer method with the classical psychoanalysis and did not even deem it advisable to bestow upon the brief approach the name Psychoanalysis.

What is Psychoanalysis? To answer this question, we can use Freud's own definition in which the master stipulates[10] that "any method of research acknowledging both transference and resistance, and pro-

ceeding from them, may consider itself as psychoanalysis, even if it reaches conclusions different from those of my method." Alexander[3] is inclined to extend the definition of psychoanalysis "to all uncovering procedures which are based on the combination of emotional discharge, insight, and integration of the newly uncovered material." Psychoanalytic therapy, according to him, includes "all the uncovering types of procedure which aim at inviting unconscious material into consciousness and then helping the patient through interpretative work to bring these newly won psychodynamic quantities into harmony with the rest of personality." The standard psychoanalytic technique is only one of the various procedures capable of achieving this aim.

We see that Freud and Alexander take a broader view in this matter than Kubie, for example, who defines a psychoanalyst as "one who is a member in good standing of any Psychoanalytic Society which is in turn a member of the international body."[25] In this question, the author subscribes fully to the views expressed by Freud and Alexander. Neither the adherence to a particular society nor the application of a particular technique can be considered as the decisive criterion as to who is and who is not an analyst. Some psychiatrists even wonder if the much advertised uniformity of training in psychoanalysis is not one of the roots of the inbreeding and orthodoxy that has isolated psychoanalysis from the rest of medicine for so many decades.

BRIEF PSYCHOTHERAPY OR BRIEF PSYCHOANALYSIS?

Participants of the Brief Psychotherapy Council made an attempt to formulate the indications for a brief psychotherapy. The result of this endeavor is interesting, inasmuch as brief psychotherapy was acclaimed as a most useful and versatile method. Indeed, in glancing over the scope of indications for brief psychotherapy, one finds it so large that one wonders what conditions, if any, remain to be treated by the prolonged method. Good results with brief psychotherapy were reported in the following disorders:

(1) *Reactive depression;* (2) *"highly schizoid character" in young men who are "more or less manifestly homosexual;"** (3) *psychopathic*

* In such cases, as a rule, the patient is "too ill for psychoanalysis;" psychoanalytic passivity is undesirable at the beginning because it activates too much anxiety, while active psychotherapy "affords a protection against the anxiety and activates it in a controlled way."

personalities; (4) *character neuroses;* (5) *delinquents;* (6) *psychotic conditions,* except schizophrenia where brief psychotherapy on psychoanalytic principles is more promising than psychoanalysis; (7) cases of a "*predominantly conversion type,*" *or where certain psychosomatic symptoms prevail;* also (8) *mild paranoid cases;** (9) *acute disturbances of fairly recent origin;* (10) *neurotic character cases* where the disturbance is not too great; (11) *some patients with neurotic symptoms;* (12) *some character difficulties;* (13) *young persons with a strict superego;* (14) *patients with a somatic disorder and a not readily recognizable neurotic symptomatology added to it;* (15) *patients whose adjustment prior to the onset of illness was fairly good;* (16) *acute anxiety syndromes;* (17) *acute symptoms, particularly vascular and gastric disturbances;* (18) *frigidity;* etc.

A not-too-important difference of opinion exists with regard to the ego integration. While Fuerst[11A] believes that brief psychotherapy is capable of building up the power of a weak ego, Kimberley,[22] Lewis,[26] *et al.* are of the opinion that it is the individual with a healthy ego structure who responds well to brief psychotherapy.

Although the breadth of indications for brief psychotherapy as stipulated by the Brief Psychotherapy Council impresses us as being rather large, we are surprised to see that, on the other hand, the general opinion of the Council as to the therapeutic results of brief psychotherapy is well on the conservative side. Judging from the official report, most participants were inclined to believe that brief psychotherapy cannot affect complete and lasting cures. Lewis who is of the opinion that most of the briefer therapies yield only temporary results, "or at least they have this reputation," wonders whether by improving these briefer therapies more permanent results can be achieved. He also questions whether by applying briefer methods "emotional" insight rather than merely "intellectual" can be attained, and whether it can bring about a change in the personality instead of only an alteration of symptoms. Rado[31] considers brief psychotherapy as a technical procedure of a palliative character. He says: "Here the aim is to relieve the patient from certain symptoms that are painful or dangerous, or aid him in handling a given situation or problem. Deeper changes in the personality are neither attempted nor possible." Contrary to him, Knight[23]

* However, brief psychotherapy is less effective in dealing with anxiety and obsessions.

finds that brief psychotherapy may sometimes have effects far beyond that of a mere symptomatic relief.

As far as the "temporary results" of brief psychotherapy are concerned, those who apply the "active" i. e. abbreviated form of psychoanalysis know that their rate of relapses after a successful treatment compares well with the cases treated by the orthodox method. The author in his more than twenty years of experience has had the opportunity to treat a great number of patients who developed "relapses" after having gone through one or more orthodox analyses. A complete absence of relapses can not be claimed by any method of psychotherapy. Grotjahn[13] reports that of the small group of nine patients suffering from psychosomatic disorders, three were seen after a long psychoanalysis. Likewise, Oberndorf in one of his papers states that a patient first seen by him in consultation in 1929, "returned after having been psychoanalyzed for longer or shorter periods by four recognized analysts—all of whom had had the benefit of organized psychoanalytical education."

It is known that some of our cases are chronically "relapsing." They concern individuals whose egos are poorly integrated and whose neurotic manifestations show recurring patterns. These people require medical aid and moral support as often as their symptoms reappear. We do well, therefore, in such cases if we suppress our narcissistic desire for "perfect cures" and offer our assistance whenever it is needed.

Fuerst believes that a combination of brief psychotherapy and psychoanalysis is feasible. This may be the case in situations where excessive anxiety hampers the application of an orthodox method. According to him, these cases respond well to a preparatory treatment by brief psychotherapy which, if desirable, can later be changed to psychoanlysis. On the other hand, brief psychotherapy can also be employed after an analysis. Thus Fuerst expects the psychiatrist to operate psychotherapy in the same manner as he operates the electric current. He wants to turn on brief psychotherapy, then switch to orthodox psychoanalysis, and finally switch back to brief psychotherapy. This may sound very helpful, but alas, it is not practicable. What Fuerst probably has in mind, is that the analyst should not insist on the application of a rigid technique, but direct his approach actively in accordance with the changes in the analytical situation. Since there cannot be any distinct borderline between "brief" and "prolonged" psychotherapy, when they are applied in succession, Fuerst's procedure as a whole deserves the name of "brief psychoanalysis." *This is the method we need most.* Dur-

ing the past decades, we have witnessed a great number of "brief psychotherapies" in their rise and fall: mesmerism, couéism, hypnotism, persuasion, suggestion, etc. It is not another brief psychotherapy that we are in want of; what we need at present is a "brief psychoanalysis," a reformed, abbreviated psychoanalysis that is freed from its ballast, and brought to an optimum of its efficiency. The reform in question will also have an important social implication. It will render Freud's epochal discovery, which up to the present day was a psychotherapy for the few, accessible to all the people.

Brief Psychotherapy and Clinic

In evaluating the results of briefer forms of psychotherapy, a great deal of misunderstanding arises from the fact that brief psychotherapy is often confused with a psychotherapy which consists of a few sessions with long intervals. The latter form is practiced–by necessity–in mental hygiene clinics. Indeed, the psychotherapy most orthodox analysts use in clinics is not a "minor psychoanalysis," but genuine Freudian psychoanalysis arbitrarily abbreviated by the individual psychoanalyst to suit the situation. We must bear in mind that the average analyst never has been really trained for an abbreviated form of psychoanalysis. If in the clinic he uses the method he has been trained to apply, he is soon likely to get into difficulties with the patient's transference and resistance, and then, discouraged and disillusioned, he may be ready to give up most of the accepted rules and to practice his own individual brand of psychotherapy. Just as it is impossible to adapt father's suit to fit the young son merely by cutting down the length of the sleeves and the pants, so it is equally impossible to apply the complicated Freudian technique to the hospital work. As a matter of fact, the Brief Psychotherapy Council was arranged pricipally for the purpose of discussing the most effective therapeutic application of psychoanalytical knowledge to clinics and hospitals. Unfortunately, instead of changing the technique so that the standards of individual psychology would be maintained, and–at the same time–the difficulties of the hospital routine would be overcome, the Brief Psychotherapy Council made another attempt to select cases that would suit a brief psychotherapy. However, the Council was neither able to establish an exact technique of, nor to recommend uniformly an exact indication for the brief psychotherapy. Therefore let us repeat: "Brief psychoanalysis" and not a vague "brief psychotherapy" is the answer to our problem.

REFORM OF THE TECHNIQUE OF INTERPRETATION

In this article the author will attempt to demonstrate how a reform of the technique of interpretation of the analytical material may improve the current psychoanalytical procedure. By virtue of this reform, some of the limitations of the method may be reduced or eliminated. The author will attempt to describe a way in which the individual treatment can be shortened while the theoretical criteria of the classical psychoanalysis, such as the management of transference, resistance, etc., as well as practical arrangements, such as the five-sessions-a-week system, etc., are maintained.

We shall start with the *interpretation of dreams*, as the most suitable example of how analytical material can be utilized in an economical way. In the early era of psychoanalysis, dream interpretation played a great part in the conduct of the treatment. The situation changed, however, in the course of time to such an extent that Freud felt compelled to criticize the analysts who "behave as though they had nothing more to say about the dream, as though the whole subject of dream theory was finished and done with."[11] Ellen Sharpe of London in her textbook on dream interpretation[37] also deplores this fact and wonders if "we are not in some danger of undervaluation" of dream interpretation as a means of analyzing patients.

The decline in the use of dream interpretation by psychoanalysts is clearly noticeable and it is to be regretted that lately a great number of analytical case reports have been published with hardly any reference to dreams as a source of evidence.

One of the causes for the decline of the interest in dreams seems to lie in the fact that, of all theories advanced by Freud, that of dream interpretation has undergone the fewest improvements and that the technique of dream analysis remained old-fashioned in many respects. Today, as in bygone days, the most time-consuming element in psychoanalysis is the system of "free associations." On the other hand, some analysts in interpreting analytical material tend towards over-simplification and the use of old and well-worn clichés. Fenichel,[6] for instance, states apodictically: "Anxiety aroused by going out onto the streets is a defense against exhibitionism." (Always?) And R. Fliess interprets the superstition of knocking on wood three times as follows:[8] "Wood=mother, finger=penis, and three=male genitalia." Such an interpretation of symptoms and symbols, based on generalizations and portraying the analyst's own associations rather than those of the patient, can-

not contribute a great deal to the progress in the art of psychoanalysis. It leads to a demand for a more clinical, inductive approach to analytical problems and for less arm-chair speculation.

This demand can be met by a change in our system of interpretation. While a full knowledge of the intrinsic processes of displacement, somatization and symbolization, is, and always will be, indispensable for the management of the neurotic symptom, we must apply our interpretative skill towards the *disclosure of psycho-dynamics* rather than hunt for the meaning of individual symbols.

Next is the question of associations. The author of this article has pointed out[15] that if the analyst succeeded in making his interpretations more independent of the patient's associations, without sacrificing the scientific basis of his work and without engaging in a mechanistic "reading" of symbols, he would undoubtedly shorten the duration of the average treatment. We must not assume that he would have to renounce associations altogether; but associations would be restricted to those points only where an independent analysis is impossible. This applies to the psychoanalytical material in general as well as to the dream material in particular.

The argument that only the use of free associations makes an interpretation "scientific" is not valid; it would be justified if we were dealing with patients who coöperate and not, as is well known, and expressed in the theory of analytical resistance, with patients who are guarding their secrets and their neurotic positions which guarantee them a relative mental equilibrium *within* their neurosis. They are always ready, if given the chance, to sabotage the therapeutic efforts of their analyst, and the easiest and commonly accepted way to do this is to offer the analyst non-essential or pre-censored information. While collecting the patient's "free associations" (which are supposed to be the ultimate authority for the analytical work) we find that the patients soon become aware of the problems in which the analyst is particularly interested, and that, consciously or unconsciously, they adjust their tactics to those of their analyst. They select from the vast reservoir of their recollections those which they deem important for the analyst, and they are particularly clever at applying this technique of associating when they notice that the analyst is on a wrong track. Indeed, patients who have undergone treatments, or have read analytical literature previously, are excellently equipped for leading the analyst astray. The constant struggle with the physician for the precious possession of the neurosis affords the patient an ultimate triumph which is all the more impressive the more

time and means have been consumed for the treatment. Judging from reports of patients, there is nothing so absurd that it cannot be presented as an "association," or cannot be accepted as an "interpretation" by the patient, particularly when the latter is in a state of transference. This is the reason why some more judicious analysts speak of "skyscraper theories built up by the magic of free associations with little regard for clinical data." (Levy).

It cannot be denied that every association, even a constructed one, may have its value, since it is a part of the patient's mind under investigation. It is equally true, however, that it may also be used as "analytical material" just as dreams and other mental phenomena studied during analysis. This characteristic of the associations, namely, that they too can be analyzed, opens for the patient the possibility of driving the analysis consciously or unconsciously onto sidetracks and developing a kind of geometrical progression of associations—a situation which, in reality, occurs not infrequently. All we have to do is to analyze the patient's associations by the use of additional associations, and to repeat the same procedure with the additional associations. It is indeed doubtful whether this way of analyzing secures a thorough scientific study of the case, but it is not doubtful that it leads to a tremendous consumption of time and effort.

Incidentally, as far as dream interpretation is concerned, "free" associations do not exist at all. Associations to dreams are determined and defined by the dream contents. How are they produced? According to Freud[11] "we ask the dreamer to free himself from the impression of the manifest dream; to turn his attention away from the dream as a whole and turn it towards the single parts of the dream content." In doing so the patient is not operating freely; he is *directed* towards the points from which his associations are to proceed. Glover confirms this when he says that by holding the patient to a particular thread, the analyst himself is breaking the association rule. "In the same way, of course, he breaks the rule if he gives preference to dreams and keeps asking for associations to dream items until he has run them through."

What value have associations even if they are free? In the general analytic production, associations are the matrix from which useful material can be drawn. Let us take an ideal case. The patient is coöperative and offers associations in abundance. Do they represent the pathogenic complexes we desire to discover? No. The analyst's effort is directed towards the discovering of common motives and intermediate thoughts, in other words, he attempts to elucidate the occult relations

between the unconscious material and the associations produced. The analyst operates with the working hypothesis that the associated ideas point toward the unconscious problems of the patient, that they have an underground connection with the latent material of the neurosis. And here is just the point where any analyst may be subject to arbitrary judgment, because there is no authority outside of his knowledge of the case, his experience and his intuition that would tell him which parts of the reports he may accept and which he may reject.

Unfortunately, the average analyst is rarely free from bias. Glover speaks of "residual training transferences," of "traditions" and of a "moralistic satisfaction" to be obtained for having expressed orthodox views, which may hamper the doctor's usual clinical acumen in evaluating the patient's material.

Many analysts allow for occasional exceptions in the conduct of the analysis;* Some tend to relax the free association rule (Abraham); others do not mind asking questions or selecting analogies in order to foster the production of the material. But a large group still favors a more perfectionistic, passive attitude and refuses to be more spontaneous in the conduct of the analysis. To use Glover's term, they often "feel guilty" in having been too spontaneous. (On the other hand, they may also feel guilty if the analysis lasts too long.)**

Brief Psychoanalysis and the Unconscious

And now let us raise the following questions: How deeply can we penetrate the unconscious unaided by the patient's free associations? Aren't we forced to remain within the sphere of the conscious material if we apply a more active technique?

In order to answer these questions we must bear in mind that we have no reliable standards by which we can judge which analytical findings are "profound" and which are "superficial." The opinions concerning this matter vary, primarily for terminological reasons. It may be claimed that our interpretations will deserve the name of being deep only if we succeed in connecting the symbolisms with an early stage of the patient's psycho-sexual development; or if we descend to the lowest level of the unconscious and to the most primordial impulses; or if we

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* Oberndorf, in one of his recent studies, mentions two cases he treated with "heretic" brevity.(30)

** "Analysts no doubt feel that lengthy analyses reflect on their technique." (Glover).

establish a relation with the earliest analogous childhood situation. (Descending to a deep level then would mean going as far back as possible in the patient's life history in order to discover some infantile pattern for the present-day reaction.) In Glover's questionnaire "the answers to the questions about 'depth' were the least satisfactory of all returned."

Stekel[37] repeatedly pointed out that although it appears to be true that most neurotic situations of the present seem to be founded on infantile patterns, we may doubt whether it is right to consider neurotic manifestations always *sub specie* of early infantile experiences, as if our present life derived its emotional character exclusively from the past. But even if our present life were an exact replica of the past, experience teaches that we can arrest the patient's neurotic development on whatever level (infantile or adult) we liberate the patient's pathogenic conflicts from their neurotic encapsulment. Today, we also realize that a reconstruction of an analogous childhood situation does not exclude the possibility that a great number of problems of the latent material, and perhaps *the basic pathogenic conflict* (which is the real "deepest root"), remain undisclosed. We should therefore be more exact with regard to the interpreation if we changed the question "deep or superficial" into the question "correct or incorrect" depending on whether or not, in the interpretation, the pathogenic problems contained in the symptom or symbol had been disclosed. Since we do not know what element of our analytical work deserves the merit of being *the* curative weapon, we cannot even claim that it is the depth of our interpretation. It seems therefore, that all we need is to discover the disturbing complexes, to establish the relative rôle they play in the patient's neurosis, and to contribute passively and actively to their solution, regardless of whether or not we have followed them as far back as the mother's womb.

Contrary to Hann Kende,[171] who is of the opinion that dreams and their interpretations in general play a lesser role in brief psychotherapy than in regular analysis, the author believes that a reform of dream analysis will greatly contribute to the shortening of the average psychoanalytical treatment and will, among other things, render the method much better suitable to the use of the hospital practice.

In the following we shall demonstrate how one-sided an analyst can be even if he uses the method of free associations, and how difficult the objective evaluation of the analytical material in such a case may become. Let us select Sharpe's dream book for our purpose. Sharpe's book is based on lectures on dream interpretation which she delivered at the London Institute of Psychoanalysis from 1934 to 1936. It is one of

the latest text-books on this subject. Her method reflects the approach to dreams as it is used and taught by the Freudian school now, and that is the reason why it is quoted here.

Case 1. The patient is an American girl who was three years in analysis with Ellen Sharpe. We are not informed about her diagnosis. From the description of the case however, we assume that the patient suffered from periodical depressions connected with agitation. According to Sharpe, the patient's "major neurotic breakdown" (the first attack?) occurred in early womanhood. At the time when she first came for treatment with the analyst, and for months thereafter, she was not able to go out alone.

The analysis, the author says, was "very incomplete" (after three years!) but the depressions passed and her anxiety alleviated. (Remission?) The patient married. She came for treatment again after eight years (recurrent attack?). She was depressed and showed again her old agoraphobia, but this time she motivated it by her urge to keep on urinating.

The analyst tells us a few facts from the patient's life. She was the daughter of a medical officer in residence at an asylum. There were serious disagreements between her parents. Her mother was absent from home most of the time, and the patient was left in the care of a nurse.

At the time of the second analysis, we learn from the patient's associations that her mother was about to return home. Then, without transition and apparently following the patient's swerving associations, the analyst talks about the patient's *sister* who has been away for years and came home with a child born abroad. Then again, the patient's associations and the analyst's report switch, and the problem of urination is discussed. The patient recalls a cat which urinated "all over the house" because of a bladder disease. She also remembers having seen in her husband's waiting room (patient's husband was a doctor) a lady who urinated on the floor. The patient is able "at this point" to recognize that her fear of passing water is "the same" as she had experienced when a child. At that time, she used to call her nurse, – "quick, Nannie, quick!"

In one of the first few hours of the second analysis the patient brings the following dream: "*I was in a bedroom and a man was giving a woman some wine and I wanted some. He didn't give me any but he came over to my bed and kissed me. I woke up feeling happier.*"

The patient associates *her sister* with this dream and reports that

when her sister arrived with her little baby, she did not want to see her at all and felt "like breaking down and crying my eyes out." We do not get any information as to why the patient did not want to see her sister, why—strangely enough—she was near a breakdown upon seeing her sister. The reader feels that apparently some important conflict about which we know nothing had existed between both sisters before. Instead of elaborating upon the topic introduced by the patient, the analyst turns unexpectedly to the aforementioned cat. The cat was a nuisance. It occupied the patient's entire attention. She tells of how little attention *her sister's* child actually required (again, the trend of the associations is directed toward the patient's sister, but it passes unheeded!) and emphasizes that despite this fact, she seemed to feel at that time as though "the whole family had descended upon her." She wished to be alone with her husband with no one to interfere.

Then we hear that at about that time her mother had returned. She invited the patient repeatedly to parties etc., not knowing that because of her phobia she was unable to attend. At last the patient told her mother about her trouble and was "amazed that she was kind and understanding." She even gave the patient money for the analysis. "Poor mother. I feel sorry for her. Why, instead of being sorry for myself, should I feel sorry for her? She is well and independent and has a gay life."

After this detail, two more or less incoherent episodes were reported: one, about the patient's excitement when she had to wait in a store; the other, about her last holiday when a storm broke out and the rain flooded her room. At this point a childhood recollection was reported. She would go to her parents' bed in the morning frequently. "That's strange to think of—as strange as thinking that mother once fed me as a baby. I shouldn't think *my sister* will have more babies." Again, the sudden association of her sister which is disregarded by the analyst. Instead of following this path, the author dwells on the patient's casual remark about her father being very fond of her, etc.

This was the material comprising several sessions before the dream occurred and the session after the dream. Sharpe then proceeded to the *interpretation*. She made the patient realize that her panic had its early setting in childhood; that her urinating phobia was due to an "aggressive phantasy of destroying by water." She pointed out "the rivalry with the mother for the father's wine, and the correlation of this rivalry with her impatience at the store(?)." The phrase "be quick, I'm going to urinate" was identical with her "rage at not being given what she wanted when she was a baby," and the act of micturition "was a hostile act

against her mother." The author showed the patient why she felt sorry for her mother; it was because of her having caused her mother—omnipotently—to stay away when the patient was little, and to have no more children after she was born.

In looking over the material of the dream and the results obtained through this interpretation, the reader cannot help feeling that this analysis, despite the apparent abundance of associations delivered and discussed, was not free from bias and not at all complete. Even if the author's interpretation was right and micturition was a substitute for destroying, the material presented in the patient's associations (a cat and a woman urinating) is no sufficient evidence for such an interpretation. Above all, it is by no means clear in what way, if any, the problem of micturition is connected with the dream reported by the patient. We hear that the bedroom scene means a jealousy scene and the bedroom, in reality, is that of the patient's parents. This interpretation may be correct; but we have hardly any material on which to base it. We must therefore assume that the analyst interpreted the dream scene by connecting with it—arbitrarily—the patient's remark about going to her parent's bed frequently when she was a baby.

We know that the patient was with her father most of the time, while her mother was absent, and that her parents did not care very much for each other. Therefore, in Sharpe's analysis, the patient's jealousy of her mother does not seem to be sufficiently motivated. No part of the patient's associations indicates it. Besides, in the dream, she does not get father's "wine," to be sure, but she gets a kiss from him and feels "happier." Nothing in the dream shows destructive hostility. We see only a desire for whatever the wine may symbolize and a kiss as a happy ending.

However, let us for a moment accept Sharpe's interpretation. What is its essence? What was the ultimate pathogenic findings of the dream? The Oedipus situation. Her sister complex was persistently neglected, although the patient brought important information in this direction. Taking the patient's material into consideration, especially the association of her sister to the woman in the bedroom; the patient's reaction toward her sister's baby; her feeling that the whole family was descending upon her when her sister arrived; her desire to be alone "with no-one to interfere," etc., the analytical reader may surmise that the dream dramatizes the patient's envy of her sister. Of course, a further investigation would have to be directed toward ascertaining this conjecture through a careful study of further communications. The analyst would

necessarily also have to clarify the rôle the sister's husband was playing in the patient's life (the kissing scene is suspicious in this respect). It seems that the patient was envying her sister her peaceful life, her happy marriage and her child, while her own life was miserable, frustrated and filled with the silly desire to urinate, which impulse, incidentally, may with equal right be considered as a symbol of the repressed sexual impulse. Perhaps the envying of her sister was a new edition of the envying of her mother. We heard her say about her mother, "she is well and independent and has a gay life." It would have only meant that some of her life situations followed infantile patterns.

The writer of this article does not maintain that the analysis attempted here is "better" than that presented by Sharpe. What he wishes to demonstrate is merely the fact that, in interpretations, even an analyst who uses associations profusely cannot avoid selecting the material. Sharpe incorporates revelations made on previous occasions into her material; on the other hand, she disregards associations which to her apparently do not seem sufficiently important. Whatever the reason for her doing so may be, a dream analysis such as that shown here helps us to correct our opinion about the ultimate authority of associations.

The "active" approach in dream interpretation is conducted in the direction from the manifest content of the dream to its latent content; from the reconstruction of the "dream situation" to the reconstruction of the patient's "problem constellation." Only after this has been accomplished is the individual symbolism analyzed.

The *simplification*, first introduced by Stekel,[39] is the most important principle of the active approach. After the manifest dream content has been reduced to a kind of précis or a headline, we attempt to ascertain the main emotion of the dream. From both, we usually derive some information about the latent dream content, at least in its bare outline. Time and again we come back to the old dreams. We analyze them in series, looking for repeated motives, for the central idea, for antithetical emotions, etc. We try to secure insight into the patient's instinctive cravings and his defense mechanisms; his anagogic and katagogic trends; his gratifications and his anxieties; in short, we lay as many cross sections through the dream as possible in order to do justice to the polymorphous structure of the dream.

An abbreviated analysis of a dream will be demonstrated in the following:

Case 2. The patient, Mary, aged thirty-two, has been suffering from an anxiety hysteria for the past two years. She was unable to travel alone in subways because of her fear that she might suffocate while the train was in motion. Choking sensations of the type of a globus hystericus added considerably to her phobia.

A dream she presented in the thirty-fourth session of her analysis ran as follows:

"In front of the house where we used to live something happened, an accident or the like, I dont know what it was. I walked out. On my way, I opened the mail box. It was filled with letters torn to pieces. Some of them had beautiful stamps (landscapes?). Then I went upstairs. The staircase was normal at first, but then became more unusual and dangerous until it looked like a gang plank of a boat, suspended high in the air. Then I saw a strange woman. She was lying in a wooden bathtub, but apparently with her clothes on. Somebody (the analyst?) said: She must be clean. This is a part of the treatment."

Our interpretation first proceeds without associations. For the sake of greater clarity, we divide the contents of the dream into four parts (headlines) as follows: (I) The Accident; (II) The torn letters; (III) The dangerous ascent; and (IV) The woman in the bathtub. Then we "simplify" each part separately.

(I) "The house where we used to live" is a reference to the patient's past. In the words ".... something happened, an accident or the like" we see a reference to a traumatic experience which apparently took place in the patient's past. The words, "I don't know what it was" contain a so-called wishful negation (Freud). They are in the service of the repressing forces and really mean "I know very well what happened; I wish, however, it had never happened."

(II) "I opened the mailbox. It was filled with letters torn to pieces." This part is obscure. A further investigation by the use of the patient's associations is required for its complete interpretation.

(III) "Then I went upstairs." The ascent as a "functional" symbol in the sense of Silberer represents the patient's flight from reality into the fantasy (= neurosis). The words "unusual" and "dangerous" used in connection with her ascent symbolize her anxiety.

(IV) According to a well known mechanism of inversion mentioned above, the picture of the "strange woman" is a substitute for a "well known woman" whose existence the patient would like to annul. She wishes the woman were a stranger. This woman must play an important part in the patient's life, since we find a definite death wish in the picture of her lying in the wooden bathtub, fully clothed, which is an allusion to lying in a coffin. A further evidence of the importance of this figure lies in the fact that the patient has used her as an object of indentification. In this cross section, the bathtub scene represents analysis. The doctor is present, and there is reference to the analysis in the sentence "this is a part of the treatment." In the words "with her clothes on" we see an indication of her resistance. The patient is not yet ready for a complete mental undressing. The sentence "she must be clean" points toward a feeling of guilt and a conflict with her superego. The patient expects from the treatment a relief of her sense of guilt as a kind of cleansing which, according to the previous statements, seems to be connected with the traumatic experience.

This is the skeleton of the latent dream content we are able to obtain through the simplification of the manifest content and without any reference to the patient's associations. This is also our working hypothesis with which we approach the dream. We are now concentrating on the patient's associations in order to learn whether any changes or retouches of the aforementioned rough interpretation may be necessary. In our case, there is only one point where associations are indispensable. It concerns the letters. We turn, therefore, to the patient's report.

Mary came from a very devout Catholic family. She worked in her father's factory as a manager, was highly intelligent and efficient in her work. Her contacts with men, however, were very limited. Four years prior to the outbreak of her neurosis she spent her summer vacation in the country. She was in the company of her former school mate, Catherine. After a few days, the girls met a young man there by the name of Charles. He seemed immediately interested in Mary, and both spent a great deal of their time together. At this point of the report, the patient admitted after strong resistance that the affair with Charles did not remain "platonic." She confessed that one night while she was taking a ride in Charles' car, the young man forced himself upon her. She resisted desperately but finally submitted. A few days later, Charles left. Mary carried on a correspondence with him for several months and cherished the hope that some day the young man would ask her to marry him. In one letter Charles wrote her that he expected to see her

soon, since he intended to come to New York, (he lived about 120 miles away). However, a short time after that, the correspondence discontinued and the girl realized that the affair was over.

About a year later, Mary learned that Catherine had been secretly married to Charles for some time. She was deeply shocked. However, as years passed, the shock wore off and the patient seemed resigned to her fate. One day, she was informed by her friends that Catherine was seriously ill, suffering from pneumonia. Mary's first impulse was to visit her friend but her grudge against her was too strong and she did not go. A period of depression followed and a few months later we see our patient in the throes of her neurosis.

"What happened to the letters you received from Charles?" she was asked.

"I burned them one day."

"All of them?"

"Yes....well, there was one exception...."

"Was it the letter wherein Charles promised to meet you in New York?"

It was correct. Under various rationalizations, she preserved this letter until she was advised to destroy it.

The material presented here by the patient in association with the dream passage concerning the letters renders the dream fully intelligible. In her dream, the patient regresses to her past ("the house where I used to live") and re-lives the fateful experience (the "accident"). The lustful character of the experience is responsible for its repetition in the dream.

At the same time, the patient discloses her secret neurotic fiction which also probably constitutes a considerable part of her day dreams. It is a fiction which helped her to annul the painful reality of having lost her lover. In her dream, she opens the mailbox—just as she used to do for years in her real life, secretly expecting to find there a letter from Charles—the letter that was announced and never received. Instead of this letter she finds "recollections of the pleasant time she and Charles spent in the country (the "beautiful stamps" with "landscapes"). Then again the picture of the betrayal comes to her mind and that of the letters she destroyed. She leaves the level of reality and ascends to the level of fantasy ("a gangplank of a boat suspended in the air"). The dethroned reality takes revenge, however, and the patient who has given up the steady basis of reality experiences anxiety as a danger signal; as a warning of what may happen to the mind that has surrendered to un-

controlled forces of fantasy. For the fact that she has preserved the letter in which Charles promises to see her proves that she still is faithful to her lover. Against all rules of logic she keeps on spinning the yarn of fantasy that everything is still as it used to be, hoping that her lover will come one day to redeem his pledge. Here the dream becomes more specific and supplements the plot touched upon in the preceding parts. The "strange woman" is Catherine. The patient expresses in this dream a death wish against her friend, a wish that apparently originated in the patient's unconscious at the time she learned of her friend's secret marriage to Charles, and which received a distinct coefficient of reality by the news of Catherine's dangerous condition. The introduction of the analyst into the dream shows us another angle of the problem: the patient's identification with Catherine. The reason for this identification is twofold. First, it serves the patient's desire to replace her friend; second, it expresses her desire to punish herself for her aggressive thoughts towards Catherine, a reaction dictated by the patient's super-ego. It is this identification with a dying person that explains to us the patient's neurotic fear of suffocation. She plays the suffocation of Catherine in her fantasy again and again, partly in order to effect magically her friend's death, and partly in order to punish herself for her evil thinking. In her words "she must be clean" and in her statement that "this is a part of her treatment" the patient offers her analyst the key to her case: the problem of her guilt. In her dream symbols she seems to say to her physician: "make me feel clean again and I will be cured." At the same time, the words, "she must be clean" which are directed toward herself, carry an admonition to remain clean and to obstain from sensual pleasure. They sound like a vow of chastity. The reason for her incomplete undressing in the dream is also twofold. In this scene the patient shows resistance to the analysis; but in the reluctance, with regard to mental undressing, she also repeats symbolically—and corrects—her experience with Charles. While at that time she vainly resisted the physical undressing, now, in her dream, she succeeds in keeping her clothes on. The above mentioned condensation of the traumatic and the therapeutic situation shows that in her transference her analyst has taken the position of her lover.

The active interpretation of this key dream which consumed not more than one session carried us straight into the heart of the patient's neurosis. We were able to explain to the patient that her phobia of suffocating was a result of *poena talionis* and that in the dream—and likewise in reality—she identified herself with her friend Catherine whose

death she secretly craved. This interpretation which later was supported by a number of additional findings, was the turning point of the analysis. We dwelled at length upon the various correlations of her feeling of guilt. Then we discussed the possibility of her consciously and rationally destroying her fiction that she still was sharing her life with Charles. After a few sessions in which other implications of the dream were analyzed, both the patient and the analyst felt that a decisive step was made toward the liquidation of the neurosis.

Conclusions

From the material presented here we may easily assume that the simplification method may be at least as concise as that based exclusively on associations. We appeal to the patient's aid only after we have gathered sufficient material through an independent analysis. By doing this we are able to sift the patient's communications and to judge the extent of his coöperation.

Active dream interpretation requires special study. To the uninformed, many interpretations arrived at in an active way may appear as a sort of hit-or-miss game, whereby the hits admittedly are prevalent. What the outsider does not realize is the underlying skill in forming simplifications, in reducing complicated dream structures to simple equations—a skill that is a product of training and experience, a skill, however, that can be transmitted and acquired.

In the above sample of dream interpretation the question of "deep" or "superficial" did not enter at all. The reader will notice that a possible connection of the dream with an analogous childhood pattern, for instance the Oedipus constellation, was neglected. The analyst's attention was focused exclusively on the problems arrived at by simplification, and the patient's associations concerning one obscure passage about the letters.

The question as to whether the patient can discharge the emotions connected with the latent dream content in this active analysis just as well as in the orthodox analysis can be answered in the affirmative. The patient is afforded enough opportunity for discharging his complexes. Of course, he does it mostly at a time when the analytical situation fa-

vors it. It is the analyst's knowledge of the case, his experience and his intuition which tell him when this opportunity has arrived.

The effect of this abreaction is exactly the same as that achieved in the orthodox way in a passive analysis. It appears that as far as the emotional discharge and the shift of cathexes is concerned, it does not make any difference whether the patient is gently guided into confessions or whether he retains the unchallenged lead. Alexander is right when he is of the opinion that it is of secondary importance which technical devices are used to bring about emotional discharge. According to him, the individual nature of the case determines whether this abreaction should take place on the couch, by the use of free associations, by a face-to-face conversation, suddenly or gradually, through the analytical interview, or through real life situations, while the patient is under the influence of analysis.

The advantages of the active approach are evident. The most important is the fact that, without jeopardizing any rule of a causal therapy and without encroaching upon the management of the analytical situation, we are able to reach our psychological objectives in a considerably shorter time. Such a procedure deserves the name of a "brief psychoanalysis." The adage of old Heraclitus that "everything flows," applies also to the methods of psychotherapy. Recent congresses, symposia and council meetings have shown not only that we are in need of improvements in our efforts to cure mental disease, but also that progressive ideas are already on the march.

BIBLIOGRAPHY

1. Abraham, Karl: "Selected Papers," Hogarth Press, London.
2. Alexander, Franz: "Proceedings of the Brief Psychotherapy Council," Institute for Psychoanalysis, Chicago, 1942.
3. Alexander, Franz: "Indications for Psychoanalytical Therapy," Bulletin of the Academy of Medicine, June 1944.
4. Proceedings of the Brief Psychotherapy Council, Institute for Psychoanalysis, Chicago, 1942.
5. Eitingon, M.: "Bericht ueber die Berliner Psychoanalytische Klinik (1920-1922)," (Report on the Berlin Psa. Clinic), Int. Zeitschr. f. Psychoanalyse, VIII, 1922.
6. Fenichel, Otto: "Remarks on Common Phobias," *The Psychoanalytic Quarterly*, XIII, 3, 1944.
7. Ferenczi, Sandor: "*Further Contributions to the Theory & Technique of Psychoanalysis*," Boni & Liveright, 1927.
8. Fliess, Robert: "Knocking on Wood," *The Psychoanalytic Quarterly*, XIII, 3, 1944.
9. Freud, Sigmund: "*The Interpretation of Dreams*," Macmillan, New York, 1932.
10. Freud, Sigmund: "Jahrb. f. Psychoanalyse, VI, page 215.
11. Freud, Sigmund: "*New Introductory Lectures on Psychoanalysis*," Norton & Co., 1933.

11a. Fuerst, Rudolph: Discussion Remarks, see 4.

12. Glover, Edward: "*An Investigation of the Technique of Psychoanalysis*," William & Wilkins, 1940.
13. Grotjahn, Martin: Discussion Remarks, see 4.
14. Gutheil, Emil A.: "Basic Outline of the Active Analytic Technique," *Psychoanalyt. Review*, XX, 1, 1933.
15. Gutheil, Emil A.: "*The Language of the Dream*," Macmillan, 1939.
16. Gutheil, Emil A.: "Psychotherapie des Prakt, Arztes," (Psychotherapy for the Gen. Practitioner), Huber, Bern, 1934.
17. Hann-Kende, Fanny: "Discussion Remarks, see 4.
18. Hornay, Karen: "*New Ways in Psychoanalysis*," Norton & Co., 1939.
19. Horsley, J. Stephan: "*Narcoanalysis*," Oxford University Press, 1943.
20. Jameison & McNeil: "Some Unsuccessful Results with Psychoanalytic Therapy," *Amer. Journal of Psychiatry*, 95, 1939.
21. Kessel and Hyman: "Value of Psychoanalysis as a Therapeutic Procedure," *Journal of the Medical Ass'n.*, 101, 1933.
22. Kimberley, Charles: Discussion Remarks, see 4.
23. Knight, Robert P.: Discussion Remarks, see 4.
24. Knight, Robert P., "Evaluation of the Results of Psychoanalytic Therapy," *Amer. Journal of Psychiatry*, 98, 3, 1941.
25. Kubie, Lawrence S.: "*Practical Aspects of Psychoanalysis*," Norton & Co., 1936.
26. Lewis, Nolan C.: Discussion Remarks, see 4.
27. Lindner, Robert: "*Rebel Without Cause*," Grune & Stratton, 1944.
28. Lorand, Sandor: "Psychotherapy in the Mental Health Clinics," *Journ. of the Mt. Sinai Hospital*, V, 4, 1938.
29. Masserman, Jules: Discussion Remarks, see 4.
30. Oberndorf, Clarence P.: "Consideration of Results with Psychoanalyt. Therapy," *Am. Journal of Psychiatry*, 99, 3, 1942.
31. Rado, Sandor: Discussion Remarks, see 4.
32. Rado, Sandor: "Psychoanalyt. Concept & Treatment of the Neuroses," *The Psychoanalytic Quarterly*, VIII, 1939.
33. Rank, Otto: "Technik der Psychoanalyse," Denticke, Vienna, 1926.
34. Reich, Wilhelm: "Charakteranalyse," Sexpol, Vienna, 1933.
35. Schilder, Paul: "*Psychotherapy*," Norton & Co., 1939.

36. Sharpe, Ellen: "*Dream Analysis*," Norton & Co., 1939.
37. Stekel, William: "*Technique of Analytical Psychotherapy*," Norton & Co.
38. Stekel, Willam: "*Dream Interpretation*," Liveright, 1943.
39. Stekel, William: "Wasmich von Freud unterscheided," (In what Freud and I differ) Fortschr. d. Sexualwissensch. & Psychoanalyse, Deuticke, Vienna, 1928.
40. Wilder, Joseph: "Facts and Figures on Psychotherapy," Paper read before the "Ass'n f. the Advancem. of Psychother.," 1942; to appear in this Journal.

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THE SOCIAL STRUCTURE OF A SCHIZOPHRENIA WARD AND ITS THERAPEUTIC FITNESS

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In a previous paper[1] I have attempted to establish a functional nexus between the distinctive symptomatology of schizophrenia and certain structural and processional elements in modern society. The following major social factors were considered in detail:

I. The number of culture-traits.

II. The number and abstractness of levels in the organization of culture-traits.

III. Dysharmonious organization of culture-traits.

IV. Rate of socio-cultural change.

V. Cultural lag. (Cf. Dysharmonious organization of culture-traits.)

VI. Dereistic ideologies and dysfunctional value-hierarchies.

VII. Segmental participation in culture. (Durkheim's polysegmentation.)

VIII. Social emphasis on the prolongation of infantile patterns.

The listing and analysis of only eight factors was purely heuristic, and does not imply that the list is either complete or final.

Shortly after the publication of this paper, I was enabled to study the social organization of the Schizophrenia Research Ward of Worcester State Hospital, Worcester, Massachusetts, having been appointed Sociologist of the Research Staff of that Hospital. The following essay is based upon more than one year of direct observation.

The purpose of this paper is to determine the extent to which the social structure of the Research Ward mitigates the difficulties which the structure of Western civilization creates for the potential schizophrenic. In other words, it attempts to evaluate the therapeutic fitness of ad-

ministrative policies in an extremely progressive mental hospital. Somewhat anticipating our conclusions, it is interesting to note that, while the administrative policies of this hospital greatly antedated my analysis of social factors in the causation of schizophrenia, the concrete setup appears to satisfy practically every sociological criterion for a suitable envionment for the shizophrenic. In brief, the social situation is therapeutically effective, and its effectiveness can be easily understood in sociological terms.

This situation is the creation of many individuals working under the leadership of men like William A. Bryan, M. D., formerly for 19 years Superintendent of Worcester State Hospital and one of the greatest living authorities on administrative psychiatry,[2] R. G. Hoskins, M. D., Ph. D., Director of Research, and A. Angyal, M. D., Ph. D., Resident Director of Research. The hospital as a whole is a community in the best sense of the word, and the spirit which pervades it is unique. My intellectual and personal debt to this institution and to its staff is tremendous.

It would be tempting to analyze the social structure of the Research Ward in terms of the eight social factors enumerated above. Such an approach to the problem would, however, be justly suspected of unintentional eclecticism. Hence I propose to offer, first of all, a straightforward description of the social situation, and to discuss the analytical implications of this situation in the second part of this essay.

I.

The Building. The Research Service has at its disposal two adjoining ground-floor wards in one of the wings of the Hospital, called Lincoln I, and Gage Hall. Lincoln I contains some offices, numerous double bed rooms for the patients, a play-room, and a lavatory. The corridors are spacious, and contain two large halls. One of these halls contains a piano. Most of the social life of the Research Service unfolds itself in these halls, since Gage Hall is locked during the day. Gage Hall contains a few offices, and a large circular hall. During the day this circular hall is sometimes used for calisthenics. At night it serves as a dormitory. In addition, the Research Service has a few scattered offices and laboratories in the basement, to which patients go only for experiments.

The Staff. Compared to other services in the hospital, the staff of the Research Service is very large. It is composed of the medical, psy-

chological, clerical, and nursing staff and attendants. In addition, it has at its disposal the facilities of the Social Service, of the Psychological Service and of the biochemistry laboratories, which serve the hospital as a whole. The size of the Research Staff creates, from the point of view of the patients, two special situations. First of all, contacts between the staff and the patients are more numerous and more frequent in this ward than in other wards. Furthermore, the patients are subjected to a large number of tests of all types.

The Patient Population. The number of patients in the Research Service fluctuates in the neighborhood of sixty. All patients are male schizophrenics of various types, belonging to all age groups, though the age-structure of the population is variable.

Obstacles to Dispersion. Although the Research Service is, in theory, a "closed ward," a certain proportion of its patients have ground-parole privileges. The patients in question are those who, were they not in the Research Wards, would normally be placed in "open" wards, i. e., in wards all of whose inmates have ground-privileges.

The ward as such is a social group, held together by more or less external and predominantly social forces emanating from the outer world, which oppose the random dispersion of the group. The social aspect of even the physical obstacles to dispersion must be stressed in this context. A barred window or a locked door straddle the social and the physical spheres. Their symbolic and affective significance, and the fact of their presence are essentially social, while their resistance to battering is non-social. The function of barred windows, locked doors, etc. in preventing escapes and in holding the ward together is obvious. It is furthermore analytically important that this part of the environment is not manipulated by the patients, but by the staff, who can lock and unlock doors, offer egress to parole patients at specified times and deny egress to non-parole patients at all times. It is because they can be manipulated by the staff but not by the patient, that we must consider these physical obstacles as socially different from the brute physical obstacles which an expanse of sea opposes to the dispersion of some small primitive tribe.

The constant presence of at least some members of the staff is another obstacle to the dispersion of the group of patients. The patients, even the more deteriorated ones, soon realize that they are confronted with more than the mere physical strength of the hospital personnel,

particularly since the use of physical force is severely restricted and even penalized, except in extreme cases of genuine self-defense. I have seen a burly attendant, completely unaware of the fact that I was watching him, take a severe mauling from a small patient, without attempting to do more than gently ward off the blows. It should be noted perhaps, that this attendant, in addition to obeying the rules, was also a very efficient and good-natured person. It is also fair to add that illnatured persons are soon dismissed, since the motto of the hospital seemed to be: "When in doubt, the patient is right, and the staff, regardless of status, is wrong." In brief, the patients realize that something more than mere concrete beings oppose their escape. They also know that escape is, to all purposes, always unsuccessful, and that the escaped patient, on being returned to the hospital, either loses his parole or else is transferred to a more rigidly controlled ward. It is also interesting to note that escape does not increase the status of the patient with his fellow-patients. In this respect, as in many others, Worcester State Hospital contrasts favorably with prisons and less efficiently and intelligently run hospitals.

Social Mobility. In this section I shall consider internal and external, as well as horizontal and vertical, mobility.[3]

I. *Horizontal Mobility*. (1) Horizontal mobility within the Research Service may involve transfer from Lincoln I to Gage Hall, or vice-versa. It is my impression that the population of Gage Hall is, generally speaking, somewhat more deteriorated than that of Lincoln I. Patients transferred temporarily to the Research Service generally room in Gage Hall. This hall offers fewer conveniences, particularly as regards privacy and the possibility of taking a nap during the daytime. Gage Hall is somewhat farther away from the central heating plant, and is thus slightly less warm in winter, though not appreciably so. Lincoln I patients tend to resent transfer to Gage Hall because some patients feel that it involves loss of status.

(2) Horizontal mobility with the Hospital. Tansfer to and from various wards is regulated by administrative and research policies. Once a program of research on old schizophrenics temporarily upset the age-structure of the ward, through an influx of older patients. Temporarily violent patients are transferred to agitated wards, but rejoin the research ward when they quiet down. Parole patients, and patients who work in various parts of the hospital, spend much time on the outside, though

their social life, friendships, etc., tend to be limited to their own wards. Patients of the Research Wards tend to think of themselves as "privileged persons," and are often seen in this light by other patients. Hence internal mobility also involves status-mobility to a certain extent. I shall discuss this further below.

II. *Vertical Mobility.* (1) External and vertical mobility cannot be differentiated, except analytically. Like rural populations, the hospital wards are periodically skimmed of their most constructive members, who recover and return to the external world, either on visits, on conditional release, or through permanent discharge. Contrariwise, all but a few wards (e. g. the agitated and the Summer-Street division) are also habitually skimmed at the bottom of violent, more or less chronic, and similar difficult cases.

Summing up, in this sense again internal factors of cohesion, which are always weak in the unsociable schizophrenic, are relatively unimportant as compared to external factors (e. g. policies of the staff) which can interrupt existing friendships through the transfer of one or both of a pair of friends to other wards or to the external world. This is a genuine, though relatively insignificant, drawback, since it further isolates the already unsociable schizophrenic. In the rare cases where these friendships promise to become the nucleus of social re-integration the patients tend to protest. Whenever justified, these protests are heeded by the staff. A more methodical consideration of this factor ought, however, to become a part of regular hospital policies.

A few theoretical considerations are in order. The dispersion, as well as the non-dispersion of the ward population is generally determined by social factors originating in a segment of the world, which, in more senses than one, is external to the patient-group. This contrasts with the social set-up of the external world, though even in society at large factors more or less external to the immedate life-space and the primary group of the individual control his social mobility or immobility. There exists, however, an even more significant analytical difference. The constituent members of society at large are often not fully aware of the nature and import of factors controlling them, which are in many respects far more impersonal and far less tangible than are factors regulating the mobility of patients. It is quite true that the schizophrenics' abstractive deficiencies[4] lessen the pragmatic value of this distinction, in that, to many of the patients, medical decisions, emanating from known physicians, seem just as "random" or "fortuitous" as "lucky" or

"unlucky" breaks seem to members of society at large. Nevertheless, with these qualifications, the schizophrenic patient is more or less aware of the concreteness and reality of the persons and forces which dictate the course of his social mobility. He generally knows whom to approach with a request for ground-parole, home visits or dismissal. He is also quite skillful in choosing intermediaries to submit his requests or complaints to the proper authorities. In the social world at large, on the other hand, impersonal factors rather than definite persons regulate the mobility of the individual. Thus, within limits, the distinction just made appears valid and therapeutically significant, since the concreteness of the social environment is a substantial gain to the disoriented[5] schizophrenic.

The logical structure of authority in a hospital is similarly an advantage to the patient confused by the generally multivalent and undefined character of situations in the external social world. Spheres of authority in the hospital are clearly delimited, and, in general, doctors tend to agree on policies. It should be stressed, however, that while in society at large medical solidarity, called "medical ethics," is often a matter of professional interests, and is not always socially useful, the situation at Worcester State Hospital is different, partly because of the careful selection of the staff, and partly because of a tradition of cooperation and effectiveness. Personally, I have never seen a physician back up another physician, when the latter had made a mistake; for the good and sufficient reason that the margin of error was cut down to the very minimum compatible with human limitations, through frequent conferences, and the fact that major decisions were taken only after careful consultations.

Even in a hospital whose standards are considerably below those of Worcester State Hospital, medical solidarity, open to criticism in other contexts, seems justifiable with regard to the schizophrenic, because it is coherent, and unequivocal in the exercise of authority, which is precisely what the schizophrenic needs most in his attempts to orient himself.

Uniformities, environmental and social. We may now examine the uniformities, characterizing the ward-environment, with special reference to the patient's bio-psychological needs. The most significant feature of any environment, from the viewpoint of the individual living in it, is the nature of the uniformities characterizing that environment. Specifically, it is my thesis that the constancy and intelligibility of certain environmental factors and processes make possible uniformities of

behavior, or, in other words, the integration of the personality and of habits, in a manner compatible with the structure of the environment.

Where the environment is unharmonious, or is subjectively perceived as unharmonious by certain standards, one tends to meet with many disorganized personalities.[6] Hence the study of the characteristic regularities or ward-processes is important, especially if it can be shown that these processes are coherent and do not involve strenuous attempts at bridging unbridgeable gaps, as is often the case in the external world, where contradictory sets of values strive for expression in one and the same environment.[7]

The most significant distinction between man and other animals is the extent to which, in man, behavior and personality tend to be patterned by environmental uniformities, rather than by innate uniformities of perception and response (so-called "instinct"). In particular, the stimulus-value of any object in the environment depends upon several factors: the specific nature of the perceiving organism, (i. e., the general relevance of that object for a given type of organism), conditioning, the temporary state of tension (or need) of that organism, (i. e., the special relevance of that object), and finally the context of the stimulus. Roughly speaking, the motivating significance of contextual factors is inversely proportional to the state of tension of the organism. If the tension is intense, the organism will take risks by disregarding the context. I have discussed this problem elsewhere[8] and need not concern myself with it in this context, where its value is purely heuristic.

Mach once stated that there are no laws in nature beyond those which we "put" into it. The same view is aptly expressed in Dewey's dictum that the data of science are "taken," not "given."[9] In schizophrenia, however, the perception of environmental uniformities is skewed beyond the basic skewing of all epistemology, to fit the delusional system, or, more broadly, schizophrenic "ideology."

The environment of the hospitalized schizophrenic is comparatively devoid of strong single stimuli and of circumstances bringing about acute states of deficiency, except as regards sex. The sexual detachment of the average schizophrenic tends, however, to minimize this need, and the mores, bolstered by law, prevent the therapist from attempting to maximize this interest in any practical way.

At any rate the objects which satisfy the need for food and shelter tend to become emotionally under-valued, because of the automatic and nearly effortless manner (e. g., tube-feeding in extreme cases) in which they are conveyed to the patient at set hours. Unless food, or similar

features of the non-social environment, happen to be deeply correlated with the specific delusional system of the individual patient, these prime necessities and their gratification tend to be taken more or less for granted. Important exceptions are orally fixated patients, or those whose religious delusions involve distinctions between "pure" and "impure" food. Food is often refused by suicidal patients, and by patients with poisoning delusions. It must be emphasized, however, that we speak in this context of food *qua* nourishment, and disregard the elaborate feeding routine, visits to the hospital cafeteria, and special cravings for tidbits from the hospital canteen, the latter being accessible only to those who have a charge-account, provided by their families. In some cases food tends to be overvalued by patients jealous of those who, because of special medical considerations, receive extra nourishment. In one case, this jealousy took such proportions in a paranoid schizophrenic as to necessitate the prescription of extra nourishment, which he decidedly did not need on somatic grounds.

Generally speaking, food anxiety, contingent as a rule upon difficulties of wresting a bare subsistence, or better, from the physical or social environment, in Kardiner's[10] sense, is absent because of the copious and healthy nourishment available to all patients. Exceptions to this rule are those patients whose individual delusional system creates food-anxiety *ex nihilo*.

Climatic conditions too are relatively devoid of significance, and do not involve concern with extremes of heat and cold, since the hospital is well heated. In the warm season most able-bodied patients work on the hospital farm. In winter outdoor work is limited to keeping the hospital roads free of snow. Hence, at the central plant only the young and able-bodied men work outdoors in winter. At the Summer-Street plant, however, which is located downtown, this work is performed by an older, though genuinely healthy, group, because of the non-availability of young men.

In winter patients tend to be more reluctant to get up in the morning. This is primarily due to the late sunrise, and to the relative lack of work. Cold, on the other hand, does not seem to be a factor, since the hospital as a whole is well heated. Were temperature a factor, one might expect the Gage Hall patients to be somewhat more troublesome in this respect than Lincoln I patients. As a matter of fact, quite the reverse is true. Lincoln I patients are, by and large, less deteriorated than are Gage Hall patients, and hence less amenable to the more irksome aspects of routine, such as getting up in the morning.

A further important seasonable difference should be noted. In winter, one finds at any given hour of the day more patients in the ward than in summer, when some are working outside in supervised gangs, while others engage in sports or other parole-pursuits. Parole patients even tend to stay indoors. Hence in winter we find, in general, more persons engaged in conversation and other social pursuits than in summer. The number of arguments and even physical clashes between patients also increases in winter. The relative dullness of the winter routine is alleviated by the all-year-round weekly moving picture, by more frequent parties for patients (including dances), and by a more active social life. On the other hand, idleness and the feeling of being "cooped up" increases destructiveness in winter, except before Christmas, when many patients prepare for the holidays, and make useful objects for the festivities. (Data furnished by the Occupational Therapy Department).

Other data connected with seasonable changes will be discussed below.

We are now prepared to turn from more or less non-social to purely social routine.

Our study of the influence of non-social factors suggests a rather interesting anology between the urban and the hospital environment. In both, the impact of physical and biological factors originating in the environment is radically softened and regulated through technological devices. Both in the hospital and in the urban environment many factors which are overwhelmingly non-social under natural conditions are transformed into predominantly social ones. Thus one's food-supply does not depend on one's own strength and skill, nor on that of hunted animals, but on the social structure which makes one individual responsible for the food-supply of another, provided only that certain formalites are adhered to in the transaction.

This analogy between the hospital and urban environment is further strengthened by an analysis of the purely social routine. Urban man devotes a larger proportion of his time to interaction with other men[11] than does primitive man.[12] Urban man is more dependent for his safety and life on social uniformities than is primitive man.

Hospital routine is enforced administrative fiat. These rules are precise, compulsory, and intelligible, and hence tend to form deeply ingrained habits, regardless of whether they are willingly or reluctantly accepted by the patient. A patient expressed this as follows: "When I went home on a visit, my first thought was: 'Now I can sleep all I want.'

For a few days I slept late, and then automatically relapsed into hospital routine as far as my bed-hours were concerned."

It is somewhat difficult to decide whether this highly uniform routine exerts, in the long run, a good or bad influence on the schizophrenic. The immediate advantages of this routine are obvious in the light of our discussion of the therapeutic importance of systematically applied authority. (It must be understood, of course, that, despite this routine, patients are treated very much as individuals, more so perhaps than is the average man in society at large). Many patients seem to feel that hospital regulations, methodically enforced, afford them a relief from the constant necessity, uncongenial to the schizophrenic, of making decisions for themselves. Other patients, especially the better preserved ones, tend to resent routine. One voluntarily committed patient states: "I don't mind going to work in the cafeteria at set hours, but I do resent being sent there fifteen minutes ahead of time and then made to wait in a cold, drafty passage." In making this statement, the patient disregarded the fact that all patients assigned to cafeteria work were not as well preserved and hence not as punctual as himself, and that the fifteen minutes in question were usually needed to round up the laggards.

In the long run this rigid routine seems conducive to what the therapist is most anxious to avoid: the so-called "institutional cure." This term denotes the condition of patients who have recovered sufficiently to adjust themselves to hospital conditions which require little initiative and afford a maximum of security. The hospital is a simplified environment, in which the patient can easily orient himself, and thus can overcome the feeling of disorientation which besets him in the more complex and less coherent external world. On the other hand, too perfect an adaptation to hospital conditions generally involves also a good adaptation of the patient's personality to his psychosis. (This statement is significant, because it emphasizes the distinction between personality and psychosis, all too often confused by the psychiatrically uninformed.) Hence too good an institutional cure makes the patient temporarily or permanently unfit to resume normal extramural life and to adapt himself to a more complex world in which personal decisions must be made. *Genuine cures are possible only as long as there is a genuine conflict between personality and psychosis; as long as the former does not become merged with or submerged in, the latter.*

A further objection to institutional cures is that automatic adaptation to routine reinforces the regressive and infantile dependency trends of the schizophrenic. (Cf. factor VIII above).

Institutional cures do not occur miraculously, but, like all types of social adaptation, require a certain amount of time for the conditioning of the individual. Institutional adaptation is encouraged by nurses and attendants, because it simplifies their work. The medical staff, on the other hand, attempts to prevent too good an institutional adaptation. A young schizophrenic took such delight in his work in the radio room, that he was assigned a less pleasant task on some flimsy excuse, lest he lose the desire to return to the extramural world. This "trick" was successful, at least for a while, since it enabled the patient to go home on a long visit.

The true import of institutional cures cannot be clarified without quoting actual cases.

(1) *Institutional cure by modification of the delusional system.*

J. D. is a powerful, aggressive paranoid schizophrenic with grandiose delusions and many hallucinations. He has all the qualities of leadership. Unable to accept the patient status, he has adapted himself to the hospital by pretending to be an employee thereof. He started classes of so-called "calisthenics," i. e., exercises of his own invention, justified by means of complex "physiological" and "psychological" theories peculiar to himself. The hospital authorities gave him a white uniform. Thus clad, he conducts his classes, outdoors in summer, in Gage Hall in winter, with a great deal of efficiency, but also with a great display of "chesty" authority. Subtly as well as openly he stresses the fact that he is not an inmate but an employee of the hospital, and uses the pronoun "we" in speaking of himself and the staff. For instance, in evaluating the therapeutic efforts of his calisthenics class on the patients he says: "We have started this project for the patients because, etc." His great strength and his cooperativeness when humored in his pretense of being a staff-member, make it worthwhile for the employees not to disturb him in his delusions of grandeur. He submits to tests, though he resents any other attempt to treat him as a patient. During the winter of 1939-40 a patients' court was instituted to take care of minor infractions of the rules, and J. D. had to be hailed into court for repeatedly refusing to get up in time. The head-nurse preferred the charges, and an attendant was called in as a witness. The presiding patient (the "judge") instructed the patient-jury to find J. D. guilty, the judge, in accordance with the ward's self-government constitution, sentenced him to one day of loss of parole. (A physician would normally have deprived him of his parole for seven to fifteen days.) The shock of being judged by his alleged inferiors was considerable. It left him subdued for days, and for six weeks he got up on the dot, with only one unintential relapse. We all expected him to react violently to this punishment, and the nurse in charge even said, "The day he is off parole, I'd rather not be on the ward." The only other occasion on which this patient was successfully deflated was during a visit of Professor Talcott Parsons of Harvard. Patient was bragging of being a structural engineer in sociology, and of having great wealth, whereupon Professor Parsons very seriously asked him for a few hundred thousand dollars for sociological research. J. D. fumbled for lame excuses and was very meek and tractable for days after.

J. A. is a tall, pleasant man in his late fifties. Despite the rarity of authentic cases of "paranoia" it is possible to classify him as such. He belongs to an open ward, and acts as hospital messenger and mail-man, because of certain special pre-

psychotic qualifications for this task. He is the only patient to whom all doors are opened without question by anyone. He plays tennis with the staff and the staff-wives and is well-liked by all. He also more or less manages the hospital intramural radio, and sings on its programs. Since his delusions center about his "persecution" by superiors in his private life, he takes pride in being an efficient mailman, as if to show that he had been unjustly persecuted. J. A. ironically refers to himself as "one of the nuts," thus slighting his patient status. What enables him to do so is the fact that, to all purposes, he is a hospital attendant, and a universal favorite. Institutional cure is perfect.

(2) *The Hospital as a shelter from wear and tear.*

E. G. is an alcoholic, who considers the hospital as a haven of refuge. When things on the outside become difficult, he goes on a spree, in order to be readmitted to the hospital, thus running away from his problems. The physician in charge of his case finally decided to break this tendency of affiliation with the hospital. Upon his last admission he was sent to the Summer-Street division, where the more deteriorated and chronic cases were lodged. Since all patients consider being to Summer Street as a "disgrace," this assignment gave the patient a great shock. He profited of his leisure-time in Summer-Street to sneak out of the hospital to get alcohol. He got drunk and started a small fire in his room—his first misconduct and his first gesture of protest against the hospital. Once again this "therapeutic trick" seems to have had the desired results.

A female patient, when interviewed by my wife (then a student social worker in the hospital), who wished to obtain the address of her nearest relatives, said: "I won't tell you anything. I know why you want those addresses. You want to send me home. I don't want to go home. I have been here for eight years, all my friends are here, and I like it here. I won't tell you anything."

In certain cases even the hospital authorities consider transfer deleterious, once hospital adjustment has been achieved by a chronic and presumably incurable patient.

An old schizophrenic patient from an open ward was being considered for transfer to the County Farm for the Aged. This patient, an immigrant, had spent most of his life in the hospital, where he washed cars. It was the only stable environment he had known all his life. The Social Service opposed his transfer on the grounds that it constituted an unwarrantable hardship on the patient. The plans for transfer were thereupon dropped, partly because the patient refused to leave.

In some cases the institutional cure is restricted to one part of the hospital.

An aged schizophrenic from an open ward had for twenty years worked on various chores in the main hospital building. Once a year he had town parole. On these occasions he was given carfare, a pack of 20 cent cigarettes and a ticket to the circus. Eventually this deteriorated patient, who spoke very little indeed, was transferred to Summer-Street. One day, shortly after his transfer, the patient stopped me and my wife, engaged us in conversation, which he had never done before, and asked us to give his regards to the main hospital matron, for whom he had worked for twenty years in the hospital. (Author and his wife

were lodged at Summer-Street, though they worked at the main hospital. Hence the patient associated them with the main hospital.) Patient seemed at first rather lonesome and lost at Summer-Street.

Patients who make a satisfactory adjustment to the hospital and achieve an institutional cure, seldom recover and almost never attempt to escape. They manifest the beginnings of genuine "community sentiment" and a "feeling of kindred." In anthropological parlance we might say that the patient has become acculturated to the hospital, and has become so well-adjusted that he is unable to become once more a citizen of society at large.

(3) *Seasonal variations in institutional affiliation-tendencies.*

J. L., a vountary commitment case, deliberately postponed his release until summer, allegedly because he did not wish to start job-hunting in winter. This was a rationalization, since he was still in the hospital in July. A young schizophrenic F. M. stated that in spring he felt an urge to go home, because "In spring a young man's fancy turns to love." He declared that he did not wish to go home in winter, since the Hospital was better than a winter's work on the W. P. A.

(4) *Relapses on Dismissal.*

The most striking phenomenon connected with institutional cures is the relapse of patients on dismissal, which is, in some respects, a phenomenon related to relapses on the termination of an analysis, or of parole.[13] Certain patients who profess to be anxious to be dismissed, and may even be unpleasant about it, have catatonic or other relapses when they are informed of a pending indefinite home-visit or outright dismissal. Sometimes relapses occur shortly after the patient is sent home.

The young schizophrenic who had been removed from his all too satisfactory radio-job was shortly afterwards sent home, in what seemed to be a good condition. Unable to get a job, and confronted with an unpleasant family-situation, he became panicky, left his family, hitchhiked back to the hospital, and went into a severe depression with hallucinations, somatic delusions, etc. In brief, he was not sufficiently prepared to face extramural social problems.

An interesting contrast of social maturation is afforded by the case of E. R.:

This patient, of French-Canadian origin, was a catatonic. In private life he was a laborer and mill-hand, and spent a year and a day in jail for arson. Every time that he was sent home to his difficult mother and indifferent wife, he had a catatonic seizure and had to be returned to the hospital in an ambulance. Previous to his last dismissal, the author used this patient as a "participant observer" of ward-life, and asked him to write detailed reports on ward-events and ward-or-

ganization. The patient did this work very conscientiously. The purpose of this assignment was to enable the patient to see society in perspective, first in the hospital, and then in society at large. He was once more sent home at Christmas. Everyone expected him to be soon returned to the hospital in a catatonic stupor. However, perhaps because of his newly acquired social insight, he did not have a relapse, though home conditions had become worse in the meantime, and his wife had deserted him. A year later he was still at large. He had found a job, emancipated himself from his mother, and no longer tried to regain the affections of his wife. His social adjustment seemed reasonably adequate, and his enuresis appeared to have subsided. It is significant that his emancipation from the hospital was not accomplished by becoming antagonistic toward it. When visited by a social worker (the writer's wife) he did not resent the visit, but acknowledged it as justified and even sent the writer his regards.

In brief, one of the principal tasks of the psychiatrist is to decide at what juncture further hospitalization is likely to jeopardize the schizophrenic's slender chances of making a genuinely social, rather than an institutional recovery. Hence it is often deemed advisable to send the patient home time and again, just to prevent too good an institutional cure. Psychiatrists are aware of the fact that prolonged hospitalization tends to result in a passive and automatic adaptation to hospital routine, with motor behavior regulated by rules and by command. It is important to realize in this context that hospital routine differs from the routine prescribed by the mores and folkways, in that it puts no premium on either initiative or choice. The fact that hospital adjustment can be achieved in terms of mere automatisms, requiring no intellectual effort, enables the patient to indulge in daydreams even while attending to his duties, thus reinforcing the schizophrenic pattern. This freedom to remain plunged in day-dreams even while going through the prescribed motions is, and must be, interfered with. This interference can be accomplished in several ways: External means and internal means. External means consist in assigning new tasks to the patient and confronting him with choices and decisions on a small scale, and, last of all, in increasing social interaction and organized social life. Such was the purpose of the afore-mentioned self-government and court, as well as that of the patients' literary club.[14] Internal techniques of interference with dream-life consist in increasing the patient's tensions. Following a course of endocrine therapy (testosterone injections) an intelligent schizophrenic, A. O., who for eight years had refused even to entertain thoughts of being boarded on the outside ("family care"), suddenly decided to ask for precisely this privilege.

Summing up, the psychiatrist must make an effort to prevent too perfect an institutional cure, even though such a cure simplifies the work

of the personnel. The extent to which this is done is a measure of the quality of the hospital. The task is a difficult one and requires a great deal of judgment, particularly since one cannot count on much effort on the part of the patient. It must be admitted, however, that occasionally a relatively old case, with a rather poor prognosis, makes a spontaneous and more or less adequate social recovery when "out on a visit." This suggests that the "instinct of combination" of the schizophrenic is not always completely submerged in the "persistence of aggregates,"(15) and may, after a period of rest and withdrawal, once more come into its own under the impact of a more varied extra-mural environment.

The Autistic Environment

So far, we have analyzed the non-social and the social environments of the schizophrenic, with special reference to the uniformities which characterize them. We are now prepared to turn our attention to the third type of environment in which the schizophrenic moves: The autistic environment of the world of fantasy, day-dreams, etc. The importance of this world is recognized by the schizophrenic himself.

> In Dr. Hoskins' office there are several charts concerning schizophrenia, one of them entitled "'Schizophrenia: a day-dream." A paranoid schizophrenic, whom I interviewed one day in Dr. Hoskins' office, fastened his eyes on this chart and said rather excitedly: "That is precisely my case: a day-dream." From that day onward communication with the patient, and the degree of his insight into his own actions were greatly increased. After the patient had completed a series of testosterone tests, he was discharged under supervision, obtained a job downtown and made a reasonably adequate social adjustment.

Two major aspects of the autistic environment are of interest. (The term "environment" is not as far-fetched and metaphorical as it may seem. The patient often creates a fantasy world, which tends to become "set" in its ways, and which, after a while, the patient can no longer change around *ad libitum.* It tends to acquire stable characteristics, which limit the patient's freedom of manipulation. Anything is "possible" in the early stages of the creation of a fantasy world, but, once that world is created, it imposes certain immutable limitations upon the patient's freedom to manipulate this world of his own making. In brief, it tends to acquire the characteristics of a true environment, characterized, in Durkheim's words, by "externality" and "constraint.")

First of all, the autistic environment performs a function which, in normal life, is performed by a viewpoint, by convictions, opinions, pre-

judices, or ideologies. (I use the word "ideology" in Schilder's sense.)[16] It provides the schizophrenic with a specific, distinctive and personal hierarchy of values, enabling him to organize his environment into a more or less constant whole, by assigning, on a subjective basis, different values to different stimuli. The more subjective this hierarchy of values, the more dereistic the patient's fantasy world tends to be. In this sense, the schizophrenic's delusional system operates as a philosophy of life, or as a blueprint which enables the patient to organize sense-impressions originating in the external world in a manner peculiar and meaningful to himself. It skews the patient's view of things in a manner not in harmony with the socially standardized skewing of external situations. If, as anyone familiar with social anthropology will concede, the social evaluation of situations also represents a skewing of reality,[17] then we must admit that the really distinctive character of the autistic environment of the schizophrenic is the fact that it is differently and uniquely skewed. The fact that it is more lopsided than are socially acceptable definitions of the situation, is only a secondary characteristic of the autistic environment, which is probably rooted in what I have termed "social negativism."[18]

The assumption that social negativism is aways involved, is a necessary one. Only in this manner can we explain the occurrence of schizophrenia even in what Sorokin[19] calls an "ideational culture," and which I, for reasons implicit in the Rosanoff-Wadsworth-Humm[20] characterization of autism, would prefer to call an "autistic culture." In theory, the potential schizophrenic should be able to adjust perfectly to an autistic culture, even if it is a highly complex one, were it not for social negativism, which forces him to dissociate himself from the major cultural trend. This dissociative and negativistic trend generally seems to take the form of a subsidiary allegiance to latent idealistic (rationalistic) and sensate (positivistic) trends. This view seems substantiated by the extremely logical argumentation of mystical theories, and by their decidedly sensual metaphors (e. g. St. John of the Cross, St. Theresa of Avila).

In brief, the schizophrenic's use of his autistic environment illustrates Caesar's dictum "Homines id quod volunt credunt." The schizophrenic's autistic environment does not suppress reality, but merely distorts it, and co-exists with it, as an ideology can coexist with the reality principle. One of the major functions of the autistic environment is to organize reality in accordance with certain basic principles, which have a great personal value for the schizophrenic, and for no one else.

As long as reality does not clash with the autistic world, reality is

perceived and organized in a manner compatible with the social background of the patient. The social insight of the patient into situations which do not affect him directly is sometimes remarkably good. On the other hand, when the two clash, as often as not it is the autistic environment which determines the manner in which reality is perceived, and organized into a whole. Like Hegel, the schizophrenic feels that if fantasy and reality do not overlap, it is just too bad for reality. "Tout comme chez nous" the cynic might add, pointing out that Pareto-an "derivations," and unwarranted prejudices in general, determine much of so-called normal conduct, and account for most of the average man's blind spots and wilful distortions of reality. In a sense this analogy is valid, since the roots of delusions and of complexes are just as unconscious as are the basic implications of the normal man's really cherished views. The cynic, however, is only partly right. The difference between prejudice and delusion is a pragmatic and economic one. The average man derives numerous tangible benefits from permitting socially shared prejudices to sway him and to distort his perception of reality.(21)

The schizophrenic, on the other hand, is a minority of one, a collectively containing one term, and is both the inventor and the sole representative of a "culture" peculiar to himself. The schizophrenic would probably reject the attempts of others to share his delusions, because he is socially negativistic. "Social negativism" is a concept which implies that much of the neurotic gain involved in being a deviant consists in the a-social or even anti-social character of one's behavior and beliefs.(22) This statement dovetails with the view I expressed elsewhere that active negativism should be interpreted less as a lack of contact with reality as a basic "contrariness" and as a desire to be the sole inhabitant of a private world.(23) In that paper I suggested an experiment to prove this point. Through a singular coincidence a very intelligent patient hit upon the same idea and tested it spontaneously.

> J. L., the already mentioned case of voluntary committment, is in excellent contact with reality and greatly interested in the nature of psychosis. E. W. is a case of so-called "simple schizophrenia," with a pronounced tendency to take other patients' clothes from the clothes-room of the ward, and claim them as his own. One day J. L. took E. W. by the arm, and, pointing to a third patient's clothes, earnestly asserted that they belonged to E. W. He furthermore warned E. W. against taking another suit of clothes, which actually belonged to E. W., by asserting that they were the property of another patient. Thereupon J. L. pretended to look away. E. W. cast a furtive glance at J. L. and, thinking himself unobserved, pounced upon his own clothes and ran from the room, as though afraid of being apprehended by J. L. The predominance of negativism over disorientation is as obvious in this case as in the case of Crow Indian "Crazy Dog Wishes to Die" types.(24)

We have already shown that, within limits, the autistic environment can be sufficiently modified to enable the patient to avoid unnecessary clashes with the official conception of the environment. Thus the grandiose J.D. rationalized his hospitalization into a belief that he is a hospital employee. This enabled him to cooperate and to reap genuine advantages, without incurring disciplinary measures which would have reminded him of his patient status, unacceptable to his self-esteem. He knew that he could aggrandize himself best by working enthusiastically, and thus claim to be a brilliant therapist, or a "structural engineer" of human affairs.

In brief, we doubt whether, from the viewpoint of concrete behavior, the autistic environment consists of much more than a distinctive personal way of skewing and organizing concrete experience for the purpose of validating one's abnormal "Weltanschauung," or else to enable one to interpret it in terms of some past "traumatic" experience, which keynotes one's view of one's own life. This statement merely paraphrases the often heard saying that "So and so's whole life was warped by the death of his mother—now he sees everything in black." In brief, the fallacy of the schizophrenic's method of skewing the world of experience is the fallacy of all attempts at finding a unique explanation or a unique mechanism, (sometimes in the form of antithetical thinking), to account for a whole range of one's experience. It is well known in philosophy that if a single principle explains everything, then it explains nothing at all, one reason being that the explanatory principle itself remains unexplained.

Skewing can take place in two spheres: In the sphere of recognition and labeling, and in the sphere of relations. "Seeing things," i. e. hallucinations, belong to the first category, as do misindentifications. Disturbances of perception regarding size, temporal and spatial relations and motivational relevance, paresthesias, as exemplified in Angyal's syndrome,[25] synesthesias, as in the mescaline psychoses[26] which resemble schizophrenia, etc., and other disturbances in the evaluation of relationships, belong to the second category. This second category is especially interesting, although relatively difficult to analyze, because, as is well known,[27] all relationships are inferential and cannot be objectified. Hence it is especially in this phase of reality-organization that the schizophrenic attempts at synthesis luxuriate. Once more the relative simplicity, familiarity and consistency of hospital routine tends to decrease chances of consistent misinterpreation, and hence impoverishes fantasy-life very successfully in some cases.

As regards the second aspect, i. e., the content proper of the autistic environment, it may be doubted whether it can exist separately and independently of the results of ill-organized reality-perception, present or past. A disturbance in the perception or evaluation of the temporal relationship of situations alone suffices to explain regression, and the alleged occurrence of "imaginary events" in the past. These can always be interpreted as retroactive corrective misinterpretations of actual past events, skewed in a manner which renders them compatible with the patient's present interests and conflicts,[28] in Horney's sense,[29] and which are in full accord with the general human tendency of seeing one's life as a unified pattern.

(It must be clearly understood that the *nature* of the "unified life-pattern" depends on present preoccupations. I examined several diaries kept by normal subjects over a period of years. At each stage, the diarists interpreted their lives as the expression of a unified pattern, but the *nature* of the pattern changed from time to time, in functional harmony with present preoccupations and recent developments. Hence I am unable to subscribe to theories of character-neurosis, and to Allport's[30] or MacIver's[31] principle of the unity of individual life.)

These shifts in the nature of self-elected life-patterns, conditioned by recent experiences, suffice to account for changes in the delusional context and in the behavior of schizophrenic patients of some years' standing.

> T. M., a paranoid schizophrenic, now recovered, went into a psychosis because of fancied persecution. On admission, his persecutory ideas centered about the policemen and the psychiatrist who "railroaded" him into the hospital. Later on, he had similar ideas about the hospital personnel, rather than about previously feared individuals.

It is beyond the scope of this paper to tackle the difficult problem of the origin and nature of autistic environments. Suffice it to postulate certain resemblances between the autistic environment and ideologies, and to assume, as a working hypothesis, that the structure and intelligibility of the social environment influence the nature and structure of the schizophrenic's autistic environment. This hypothesis seems moderate enough in view of the findings contained in my previous paper,[32] as well as in view of the findings of Wissenssoziologen[33] and of Schilder[34] regarding the nature of ideologies.

Having analyzed the hospitalized schizophrenic's three environments: the non-social, the social and the autistic, we are now prepared

to investigate the general problem of the hospitalized patient's orientation and re-orientation within the hospital itself, which is the central criterion of therapeutic effectiveness and social adjustment.

II.

Hospitalization and Orientation. On being admitted to the hospital, the schizophrenic unexpectedly finds himself in a social environment characterized by a high degree of simplicity, intelligibility and self-consistency. In this environment he is often capable of achieving a partial or total re-integration of his personality, because he is able to orient himself in his new environment. It is also true however, that the very ease with which this orientation is accomplished, and the scant effort required to adapt oneself to this environment, may lead to mere passive adaptation, which gives enough leisure to the patient to enable him to elaborate further his delusional system, or to devote a great deal of the time normally required by practical pursuits and by attempts to deal with emergencies, to preoccupation with remote and irrelevant topics. It is even possible that the dullnes of hospital routine, which seldom brings into play the patient's latent energies, actually induces the patient to seek thrills and self-dramatizing opportunities in the world of fancy. Thus he may slip by degrees into mere institutional cure. It is hence one of the tasks of the psychiatrist to decide at which juncture the patient is sufficiently oriented to assume responsibilities not merely for himself (parole), but also for others.

This decision involves delicate issues, because certain factors tend to diminish the intelligibility of the hospital-environment, and the willingness of the patient to become adapted thereto. First admission, unless it occurs in a state of great confusion, depression, withdrawal or acute panic, is likely to elicit one or both of the following reactions to hospitalization:

1. The socially conditioned shame of being hospitalized. Patients often mention this factor. They like to dwell on the traumatic aspects of the circumstances under which their transfer to the hospital took place, and comment on the indignity of being labelled "insane."

2. A lack of understanding of the nature and purpose of hospital routine, so different from their habitual surroundings. This is especially obvious in a State Hospital, whose inhabitants are, by and large, recruited from among the members of the less intellectual, less privileged, and

less cosmopolitan classes, who lack the mundane plasticity of the upper strata.

Worcester State Hospital attempts to minimize the initial adjustment and orientation difficulties, by sending each newly admitted patient a letter of orientation.[35] Unfortunately, this letter merely informs them of the nature of the rules which they are expected to obey, but does not enlighten them regarding therapy in general.

Rowland[36] has aptly stated that mental hospitals and their subdivisions have a tradition and folk-lore. Part of this tradition is a mass of misinformation regarding the factual set-up, which, however, is believed by numerous patients, although it does not dovetail with their personal experience. They nevertheless circulate these rumours, though I might add that rumours of an imaginery nature generally refer to happenings in "other" wards. Such being the case, the newly admitted patient is often deliberately or unintentionally misinformed by older inmates, whose false reports concerning ill-treatment are the more willingly listened to, as they agree with popular myths regarding torture in mental hospitals. It may be suspected that some of the older patients who "know the ropes" take a malicious delight in frightening the newcomers with tales of horror. Because of the shock accompanying first hospitalization, and the general sense of being imposed upon, these tales are given credence by intelligent and well-educated patients.

> T. M. states that on his admission he was "nearly scared to death" by stories of torture retailed by older patients. A study of ten patients, who were encouraged to complain of everything they could think of, indicates that most complaints are of an altogether trivial character. The one exception seems to be the patients' lack of information regarding the nature of tests. F. S., a middle-aged paranoid schizophrenic, constantly complained that he was being tested without his consent. He asserts that were the purpose of these tests explained to him, he might be found willing to submit to them. This complaint is a pleasant fiction, since the patient in question would be unable to grasp the meaning of the tests, and their significance for his own welfare and that of the community at large.
>
> Reactions to tests tend to be articulated with the patients' delusional systems. Injections are not unwelcome to F. M., who tends to stick pins in his body, while they exasperate A.O. whose persecutory notions include a fear of injections. Sometimes the treatment as a whole is not intelligible to the patient, partly because he refuses to admit that he needs any therapy. At any rate he finds it difficult to impute a plausible motive to his alleged tormentors. W. N., a college-bred young man of excellent social background, complained to an outside attendant that he was frightened by insulin therapy, and by other patients' accounts of shock-therapy in general. "I cannot figure out why doctors should want to harm me," he said, though he definitely felt that he was being harmed. Patients are, in general, afraid of shock-therapy, and one of them who, if we are to believe him, had to receive two injections before he "went under," while others were already "groaning and foaming at the mouth," seemed to derive some satisfacton and pride from

his imperviousness to insulin shock. Be that as it may, fear of shock-therapy is an unfortunate and more or less unavoidable problem, and one which should give rise to some concern, since the theory that the frightfulness of shock-therapy was the therapeutic agent has now been completely disposed of.(37)

These obstacles to orientation within the hospital call for a further intensive orientation program. A very important preliminary step toward the reintegration of the patient as a socio-psycho-biological unit(38) is the patient's discovery that he is oriented in his immediate environment. The patient makes this discovery at a time when the hospital environment begins to be a more important factor in his psychic economy than is the extra-mural world. When we enable him to cope with a special and simplified social structure, we can, as in the case of E. R., begin to prepare him for the task of re-organizing his conception of society at large.

There is no doubt that this can be accomplished. Many patients derive almost a sense of victory from the realization that they have "learned the ropes," i. e., that they have mastered their new environment and found their place in it. This is expressed directly in the form of rational and critical discussions of the hospital, in attempts to play the mentor to new patients and even to new staff-members,(39) and even more clearly, though somewhat indirectly, in direct attempts at organization and in the developing of a sense of pride in one's social status within the hospital system. I cannot, however, concur with Rowland's(40) analysis of the pseudo-functionary, or stool-pigeon patients, at least with reference to the schizophrenic, provided only we do not confuse them with ward-bullies. Becoming a "pseudo-functionary," particularly an elected one, is a definite attempt at social re-integration. It is not just an attempt to span the two worlds "patient" and "staff," for simple and sufficient reason that schizophrenics do not tend to develop a social system of their own. Rather is it an attempt to side with social reality, as represented by the staff, and to dissociate oneself from the chaotic, self-centered and structureless atomism of the patient-herd. (I use the latter term advisedly, since Rowland(41) aptly compares the patients, taken as a group, to the psychologist's "herd.") This involves an important step forward, in that the integration cannot be accomplished without a soft-pedalling of overt social negativism. It should be stressed furthermore that the hospital rules are consistently in harmony with the interests of patients. Most of the complaints recorded refer to breaches of regulations on the party of untidy fellow-patients, who thereby inconvenience their fellows, (e. g., stopping up toilet bowls, making noises, messing up the beds

during daytime, etc.) In brief, I differ from Rowland, in that I cannot consider the schizophrenic group as an organized society, regardless of how broadly the term "society," or even "group" is used. Since we cannot properly speak of group-conflict or dual organization, I do not feel that the terms "stool-pigeon" or "tattle-tale" adequately describe the situation. The terms in question denote a sense of betrayal of the organized ethics of a given group, and since there is neither an organized group, nor an organized group-ideology of an ethical character, however aberrant it may be, there can be no *sense* of betrayal, and hence no betrayal at all. The argument is clinched when we remember two basic attitudes of the schizophrenic, both of which are functionally connected with lack of insight: (a) In cases where the ego is relatively well preserved the patient insists that he is a normal member of society (cf. J. D.'s pretence that he is an official of the hospital) and hence asserts his solidarity with society and its representatives. (b) Patients grossly inconvenience one another by their peculiarities, and all the better preserved schizophrenics speak of their fellow-patients as "those crazy guys," or "the nuts" (cf. J. R.'s ironic crack, "I'm one of the nuts"). Hence they either avoid contact with them, or else, when driven to it by sheer need of companionship, not extinct even in many greatly deteriorated schizophrenics, they "regularize" the situation by saying that *their* friends are O. K.[42] Some paranoids carry this vindication so far, particularly when they are not themselves inclined to form personal relations, as to declare that all patients are sane. W. N., the college-graduate, unable to accept his present situation, consistently referred to the patients' self-government organization as the "student government," and to the patients as "the students."

Be that as it may, the acquisition of some regular status, or even of some regular task other than polishing the floors, helps the patient find his place in the hospital society, by giving him a fixed position in the social framework, which may serve as a basis or point of reference for valuative decision. This is a general characteristic of the very concept of status.[43]

F. S., one time president of the Literary Club, moved at one of the club-meetings that the officers of the club be exempted from "shots in the buttocks." During one of the ward-meetings, which was devoted to the final formulation and adoption of the ward-constitution, a parole visitor from another ward stated that he envied the ward for this exceptional opportunity and privilege, and urged them to take proper pride in it. In view of the enhanced self-regard of the president of the Literary Club, which I just mentioned, this advice was somewhat superfluous. As in society at large, office and office-holding soon tends to become in-

herently "good."(44) F. S., the patient just mentioned, was submitted to a routine test of social attitudes and asked whether he approved of the patient officials. He replied that he could not help approving of them, since he himself was president of the literary club at that time. The most conspicuous example of the therapeutic effects of "having status" is the case of T. M. This highly intelligent paranoid schizophrenic believed that the doctors had ordered him to be mute, and did not speak for months. On being elected president of the literary club he had to speak in order to conduct the meetings, and speak he did. Shortly afterwards he made a sufficient recovery to be sent home. It is interesting to mention that after his release he began to send small sums of money to support the literary club.

The same therapeutic effect may also be attributed to work, since a profession, however humble, tends to give a person a reasonably clear-cut status in our society.(45)

T. M., the patient just mentioned, was being examined for discharge. On being asked what had been most helpful in his rehabilitation, he replied, "Work." (He had been out of work and in straitened circumstances before his breakdown).

Perhaps the most conspicuous example of the human need for social differentiation and stratification is the differential prestige of certain wards. As already stated, Summer-Street wards are considered by the patients to form the bottom of the social ladder. The continued treatment (an euphemism for "chronic") wards rank, according to the patients, below the acute wards. The top-ranking position of the Research Ward is acknowledged not merely by the Research patients, but even by the inmates of other wards. This is interesting, since the Research Service is a "closed" ward, and "open" wards outrank, as a whole, the "closed" acute wards. At any rate, the Research patients take a sort of left-handed pride in their status. When a continued treatment patient attempted to join a Research patient on a walk, the latter protested. "I belong to the Research Ward. Why don't you join someone of your own group?" In the Research Ward itself, patient officials outrank other patients, and, as already stated, take a considerable pride in their exalted status.

At any rate, morale in the ward improved considerably after the Literary Club and the self-government system came into being.

Patients published and sold a mimeographed magazine "The Current," and used the profits to improve the ward in general, and the editorial office in special, purchasing a radio, buying books, subscribing to the Literary Guild, etc. The orderliness of the editorial offices was jealously supervised by the officer of the day, to the extent that it was sometimes a genuine problem to get him out of the office in time for meals. In particular they objected to the presence of non-officers in the editorial room. Further data on the club were made available in print by the club's advisor, N. Blackman, M. D.(46)

Summing up, the point we wish to make in connection with social stratification is a simple one: Status-occupancy involves two analytically different processes: (a) Society assigns a status to an individual, and (b) The individual assigns himself to that status. The important factor is the second one, since in ascribing oneself to a status, one *ipso facto* expresses one's conviction that one possesses a certain insight into, and a mastery of one's environment, which is precisely the weakest part of the social adaptability of the schozophrenic. Hence the introduction of social therapy into hospitals which justly, though perhaps somewhat one-sidedly, approach the patient primarily as an individual-absolute, promises, through status-formation, to decrease the number of second admissions, and to shorten the period of hospitalization for many, provided that care is taken to avoid an institutional cure through a too consistent stabilization of status-memberships. This can be accomplished in several obvious ways, only one or two of which need to be mentioned: (a) social mobility must be maintained by making both the assigning and the holding of status a matter of continuous achievement,[47] evaluated in terms of universalistic criteria, and (b) the traumatic reprisals for nonfeasance, both in office and in an unofficial capacity, must be applied judiciously, e. g., as when J. D. was hailed into court by his alleged inferiors, or when N. S. was deprived, on some flimsy excuse, of too pleasant an occupation which threatened to lead to an institutional cure.

So far we have examined the basic, and relatively impersonal structural aspects of social life in the schizophrenic wards of the Research Service. We have found that, since non-social factors were relatively insignificant in hospital-life, the problem confronting the therapist is essentially a social one. By increasing the patient's orientation within, and mastery of, the hospital environment, an important advance is made in the direction of the reintegration of his total personality, in the broadest sense of the term "personality" as used by Angyal. There can be no integration of the *human* personality, which depends on conditioning for integration, without an adequate orientation in an environment which must be conceived of as self-consistent and unified, and in which the individual is assigned a distinctive place to which he eventually tends to assign himself quite automatically, by the simple expedient of evolving what W. James[48] and Horney[49] call the "social self," and what Cooley[50] calls the "looking-glass self." We have found, furthermore, that the structure and rules of the hospital are therapeutically efficient because they soft-pedal the eight social factors which we hold responsible for schizophrenic breakdowns.

III.

In sections I and II we have analyzed the structural and processual uniformities of hospital society. We must, however, draw a sharp distinction between social and non-social regularities and uniformities. In general terms: That which in one universe of discourse is a significant uniformity, may appear as an accident in terms of another universe of discourse. A biological process, which obeys every biological law, may be a disturbing accident in a social situation which is structured along different lines. The wheeze of an asthmatic is a phenomenon which is consistent with every law of biology, though it is a highly disturbing accident during a sermon. Society does not suppress the laws of physics, biology, and psychology, but merely attempts to coordinate them with the social structure. Whenever physical, biological, or psychological phenomena manifest themselves in a social context in their true character (e. g., as biological, not as social ones) they form nuclei of friction. Summing up, the uniformities of one universe of discourse are the accidents of another universe of discourse. Thus, in my analysis of functioning units in a primitive society,[51] I was compelled to define the individual (socially) as a "trouble unit," since whenever the individual as such began to operate in terms of his own personality rather than in terms of his status in the social structure, he invariably became a source of friction. It is quite clear, in view of what has gone before, that in manifesting behavior wholly understandable in terms of the laws of psychology, and strictly "uniform" in psychological terms, the individual violates social laws, since the laws of psychology and the laws of society are not necessarily congruent.

This distinction is identical with the distinction between institutional behavior and behavior in terms of one's distinctive personality. In more concrete terms, I may be able to predict the outcome of my trial either because I know the law, or else because I know the judge. I. e., judge X is known to take such and such a view of a given situation. This view wholly dovetails with Cardozo's theory of the judicial process[52] in special, and with the findings of the sociologists of knowledge concerning the existential basis of ideologies[53] in general.

In order to clarify this point, I shall borrow the terms (and their definition): "a" and "any" from Russell,[54] "spatial ensemble" and "temporal ensemble" from Gibbs,[55] "simultaneous causality" and "succedaneous causality" from Petzoldt,[56] and "the definition of the situation" from W. I. Thomas.[57]

In normal society we distinguish analytically between expectations regarding the behavior of "any" policeman in "a" given situation, from the behavior of "my" wife in "any" given situation. The first expectation is social: "any" policeman will "define the situation" in the same way. We are dealing here with a spatial ensemble, and with simultaneous causality. The second expectation is psychological or existential: "my" wife will "define the situation" ("any" situation) in the same way. We are dealing here with a temporal ensemble, and with succedaneous causality. In Park's words,[58] I have "knowledge about" the policeman, and "acquaintance with" my wife. I am oriented with regard to the policeman in sociological terms, and with regard to my wife in psychological terms. I know what the policeman will do, because he is a policeman (Parsons' "universalistic criteria").[59] I know what my wife will do, because I know what kind of a *person* she is (Parsons' "particularistic criteria").

Thus, through acquaintance and the *relative* consistency of the personality pattern, we can become oriented with regard to individuals, even though these psychological uniformities may cut across social uniformities. This familiarity and orientation becomes possible through "expressive behavior," in Allport's sense.[60]

Now it is a significant pecularity of the situation in a schizophrenic ward that existentially determined activities tend to remain irregular and unpredictable. This is due to several factors:

(1) The schizophrenic's personality is disorganized; his behavior is inconsistent and bizarre.[61]

(2) His expressive behavior is highly attenuated, and hence hard to "read."

(3) His affect is "inappropriate," e.g., he laughs when he "ought" to cry.

(4) His effect is "inadequate;" e. g., he bellows with laughter where a smile would suffice and he smiles wanly when a loud guffaw is indicated.

In brief, a schizophrenic is highly unpredictable, except perhaps to the psychiatrist, who predicts behavior in diagnostic terms rather than in terms of the patient's "personality"—or what is left of it.

Consider now the case of a reasonably well-preserved schizophrenic. Two kinds of people form his human environment. First of all there is the staff, composed of normal people. He can more or less predict

their behavior, because their personalities are coherent and intelligible. I say "more or less" because some of the staff's behavior is frequently motivated by medical considerations incomprehensible to the layman, while at other times it is motivated by the patient's own bizarre reactions, into which the patient has no insight. Last of all, some of the staff's behavior is motivated by existential factors (e. g., a doctor gets engaged, a nurse loses her mother), of which the patient is not cognizant at first, though he soon learns of it through gossip,[62] or else through the hospital newspaper. Speaking in general, the patients are not greatly handicapped in evaluating the personalities of the staff, and manage to predict the behavior of staff-members reasonably well.

Next, the patient is surrounded by other patients, whose behavior is well-night unpredictable, except insofar that it may be known that J. D. is a bully, E. L. highly irritable, or H. F. amorous. He is constantly surrounded by unpredictable people, who one minute may assault him, and the next minute try to hug him. We often say that to be forewarned is to be forearmed. The fact is that the patient is not forewarned, except insofar that "anything might happen," and hence he cannot be forearmed. This leads to a great deal of anxiety, provided that we agree with Mowrer[63] that anxiety is due to a feeling that one is not adequately prepared to cope with problems. The fact that a disturbed patient can create a great deal of upheaval among his fellows is interesting, since the schizophrenic is, generally speaking, singularly unresponsive to all kinds of happenings. The fact that such disturbances do upset him shows, I believe, that he feels insecure in his relationships with his fellows. Since patients are unable to cope with this problem, the administration is compelled to remove agitated patients to the "packs" or to disturbed wards until they quiet down.

The situation just described explains two things at least:

(1) The lack of really intimate relationships between patients, and the tendency of certain more outgoing patients to establish a highly one-sided "rapport" with catatonics or completely passive patients, who are not likely to respond at all, which means: they are not likely to do anything unexpected. Rowland rightly compares[64] this to the suitableness of babies for outpourings of affection. The baby, like the catatonic, is more or less helpless and unresponsive and hence cannot protest against being made the object of affection. (I know someone who was in love with a rather disquieting woman. One day he said to her: "Go away,

and don't disturb through your presence my happy thoughts about you. You interfere with my love for you.") At any rate, one frequently sees an over-affectionate patient hug a deteriorated patient who seems indifferent to it.

(2) The presence of "stool pigeons." The fact is that most patients are afraid of one another, because a "friend" may, at any time, assault one. Since they feel unable to cope with such unexpected situations, the better preserved patients seek protection through cooperation with the staff. I. e., some patients habitually aid attendants in restraining assaultive patients, or else warn the staff that so-and-so is on the rampage. Only very well-preserved patients undertake to restrain, or even avenge, assaults against themselves, friends, or fellow-patients. In this they cannot count on support from a nonexistent public opinion, but have to hope for approval on the part of the medical staff, which is forthcoming only where revenge is not involved. One of the most difficult things is to learn to take assaults impersonally. It requires a great deal of psychiatric sophistication (like learning not to kick the chair on which one barked one's shin), and a considerable amount of practical experience with psychotics. (Some newly inducted attendants who are slow to learn this are dismissed.) Since avenging wrongs done to others cannot be justified, in the hospital, in terms of the prevalent social mores, the self-appointed avenger tends to justify his acts in terms of the mores of the extramural world.

> C. F. stated: "I know I ought not have hit W. H. who assaulted J. L. But anytime a man hits one smaller than himself, I will avenge it all the same. I did that all my life."

Deplorable as such "revenges" may be in terms of the hospital structure, they nevertheless indicate a tendency on the part of the avenger to re-integrate himself with the extra-mural social mores. As a matter of fact, C. F. was shortly thereafter declared fit to return to his family.

In this sense again the creation of "pseudo-officials" is therapeutically advantageous. It gives a measure of social sanction to the restraining actions of these pseudo-officials, which they would lack were they to interfere with troublesome patients in the absence of "public opinion." It enables other patients to look to them for protection, since their "official status" induces them to define "any" situation in a predictable manner. (Cf. above comments about the policeman.) Last of all, their attempt to adapt themselves to the "official status" helps these "pseudo-

officials" to overcome the delusional tinge of their existing "definition of the situation" and gradually adjusts them to the normal social mores.

Generalizing the above considerations, it is an obvious duty of the hospital to see to it that patients interact as much as possible within the framework of the social structure of the hospital, rather than informally This is accomplished by giving even "informal" social pursuits a definite and institutionalized place within the hospital framework, by *organizing* "informal" dances, ping-pong tournaments, and ward self-government, and by encouraging participation in these activities. This diminishes the possibility that a patient will "define the situation" in terms too personal for the comfort of his fellow patients. Outbursts are rare during organized activities, perhaps because the "official" and non-experimental character of these occasions is quite obvious to the patients. Yet the fact that games, dances, etc. involve inter-action between patients and are theoretically "informal" enables the patient to preserve the illusion of his own spontaneity, and permits him to interact with his fellows—a very necessary thing—with a minimum of risk to himself. Thus this interaction is a nucleus for the formation of an *ésprit de corps*, and hence of social adjustment in general.

Summing up, in part III we have investigated the problem of coping, within the social framework of the hospital, with the chaotic and unpredictable human factor. We have show that the personality of the patients is such as to disturb the orientation of other patients, and that specific devices are used both by patients (i. e. "stool pigeoning," "pseudo-officialdom") and by the hospital (organized "informal" group activities) to permit predictable interaction on the person-to-person level. The actual content of these relations has been described by Rowland,[56] which frees us from the necessity of describing it in detail.

SUMMARY AND CONCLUSIONS

We have investigated the social life of patients in a schizophrenic ward and have attempted to analyze the therapeutic implications and significance of the social structure of that ward. In particular we have attempted to show that hospital life attenuates and sometimes even eliminates those social factors which we have elsewhere held at last partly responsible for the occurrence of schizophrenia in advanced societies.

It was possible to show that the therapeutic value of hospitalization as such was due to the following structural factors:

I. The relative simplicity of the hospital's social life.

II. The concreteness of the social structure.

III. The high degree of self-consistency of hospital mores in general, and of social control in particular.

IV. The relatively slow rate of social change, despite a relatively high rate of social mobility.

V. The comparative absence of cultural lag.

VI. The extreme rationality of value-systems prevailing in the hospital, except where legally enforced extra-mural mores are involved.

VII. The consistent effort to induce the patient to participate in the total life of the hospital.

VIII. The social emphasis on the growing-up process.

In comparing this list to the set of factors which we have held responsible for schizophrenic "breakdowns," it is obvious that the hospital environment is therapeutically successful, because it emphasizes the exact opposite of those social factors which lead to schizophrenic "breakdowns."

On the other hand we have pointed out that the very ease of adaptation which this rational, coherent and simplified environment makes possible, may, on occasion, constitute a danger to the patient, since it encourages "institutional cures," and the ease of adaptation permits further intensive preoccupation with delusions and other autistic productions.

On the level of person-to-person relationships and in interpersonal orientation we have emphasized the problems arising from the unpredictability of patients, and have shown that this difficulty is partly overcome through an effort on the part of the patient to identify himself with the staff and with acceptable social mores, so that even this difficulty is ultimately constructive and conducive to recovery.

However, we did not fail to note that this "compensatory" form of recovery occurs without the preliminary creation of intimate person-to-person relationships, despite the fact that "informal" but more or less officially organized entertainments tend to encourage such relationships. Hence, many patients, leave the hospital willing and able to adjust themselves to the mores in general and to the more generalized aspects of the social structure, but unprepared and unable to cope with problems arising out of interpersonal relationships as such, i. e., love, friendship, etc. Hence, patients out on parole often have new breakdowns when they are confronted with problematic and tension-creating personal relationships. We must remember in this context that the hospital personnel makes no personal demands upon the patients, and displays a degree of tolerance and disinterestedness absent in society at large.

Only by overcoming certain legally imposed restrictions, and by a consequent broadening of human relationships between staff and patients, perhaps along the lines suggested in the later works of Ferenczi, will mental hospitals be enabled to prepare the recovered patients adequately for the most dangerous and chaotic of all human relationships: Those relationships in which persons interact not in terms of their respective statuses and generally on a functionally specific level, but in terms of their personalities, and preferably on the functionally diffuse level. Until a patient is enabled to initiate, manage and sever affectively significant relationships in all their complexity,[66] recovery is generally a temporary one. The responsibility for this incomplete therapy cannot be placed upon the shoulders of the psychiatrist, but must be laid at the door of archaic social ideologies, bolstered by laws, which would rather abandon individuals to insanity than consign dysfunctional ideologies to oblivion.

The schizophrenic was broken by society, and, so far, society has been unwilling to go the whole way in enabling the psychiatrist to apply all of his skill and insight to the task of restructuring the total personality of the schizophrenic. It can be stated without fear of contradiction on the part of competent persons, that a further expansion and implementation of applied medical knowledge rests with the legislator and not with the psychiatrist. We will not have efficient and complete therapy until the medical practitioner is enabled by law to apply every bit of knowledge which he possesses without fear of a public outcry against alleged violations of archaic mores.

Were the schizophrenia problem less acute, we might claim that it is better to have a handful of schizophrenics than to abolish—with regard to medical practice—certain purportedly "ethical" tenets. As it is, schizophrenic costs the public $1,000,000 a day, and more hospital beds are occupied by schizophrenics than by tuberculotics. The social cost of schizophrenia is so large as to justify a purely rationalistic approach to the problem. We have the means—the question is: Shall we be permitted to use them?

FOOTNOTES

1. Devereux, G., A Sociological Theory of Schizophrenia. *Psychoanalytic Review* 26:315-342, 1939.
2. Bryan, W. A., *Administrative Psychiatry*, New York, 1936.
3. Sorokin, P. A., *Social Mobility*, New York, 1927.
4. Devereux, Schizophrenia, *op. cit.*
5. *ibid.*
6. cf. Symposium on Individual and Social Disorganization. *American Journal of Sociology*, Vol. 42, No. 6, May, 1937.
7. Bain, R., Our Schizoid Culture. *Sociology and Social Research*, 19:266-276, 1935. Lynd, R. H., *Knowledge for What?* Princeton, 1939.
8. Devereux, G., Motivation and Control of Crime. *Journal of Criminal Psychopathology*. 3:553-584, 1942.
9. Bain, R., Sociology and the Other Sciences. *Scientific Monthly*, 53:1-10, 1941. Dewey, J., *Logic, The Theory of Inquiry*. New York, 1938.
10. Kardiner, A., *The Individual and his Society*. New York, 1939.
11. Sorokin, P. A., & Berger, C., *Time Budgets of Human Behavior*. Cambridge, 1939.
12. Provinse, J. H., Cooperative Ricefield Cultivation among the Siang Dyaks of Central Borneo. *American Anthropologist*, N. S. 39:77-102, 1937.
13. Devereux, Motivation and Control of Crime, *op. cit.*
14. Blackman, N., Experiences with a Literary Club in the Group Treatment of Schizophrenia. *Occupational Therapy and Rehabilitation*, 19:293-305, 1940.
15. Pareto, V., *The Mind and Society*. (4 vols.) New York, 1935.
16. Schilder, P., The Analysis of Ideologies as a Psychotherapeutic Method, Especially in Group Treatment. *American Journal of Psychiatry*, 93:601-615, 1936.
17. Devereux, G., Maladjustment and Social Neurosis. *American Sociological Review*. 4:844-851, 1939.
18. Devereux, G., Social Negativism and Criminal Psychopathology. *Journal of Criminal Psychopathology*, 1:323-338, 1940.
19. Sorokin, P. A., *Social and Cultural Dynamcs*. (4 vols.) Cincinnati, 1937-1941. id. *The Crisis of Our Age*, New York, 1941.
20. Humm, D. C., Personality and Adjustment. *Journal of Psychology*, 13:109-134, 1942.
21. Devereux, Maladjustment, *op. cit.*
22. Devereux,, Social Negativism, *op. cit.*
23. Devereux, Schizophrenia, *op. cit.*
24. Lowie, R. H., *The Crow Indians*, New York, 1935.

25. Angyal, A., The Perceptual Basis of Somatic Delusions in a Case of Schizophrenia. *Archives of Neurology and Psychiatry*, 34:270-279, 1935. *id.* The Experence of the Body-Self in Schizophrenia. *ibid.* 35:1029-1053, 1936.
id. Phenomena Resembling Lilliputian Hallucinations in Schizophrenia. *ibid.* 36:34-41, 1936.
id. Disturbances of Activity in a Case of Schizophrenia. *ibid.* 38:1047-1054, 1937.
26. Stockings, G. T., A Clinical Study of the Mescaline Psychosis, with Special Reference to the Mechanism of the Genesis of Schizophrenia and other Psychotic States. *Journal of Mental Science*. 86:29-47, 1940.
La Barre, W., The Peyote Cult. *Yale Uinversity Publications in Anthropology*. No. 19, New Haven, 1938. (Exhaustive Bibliography).
27. MacIver, R. M., The Imputation of Motives. *American Journal of Sociology*. 46: 1-12, 1940.
id. Social Causation. Boston, 1942.
28. Devereux, Motivation and Control of Crime. *op. cit.*
29. Horney, K., *The Neurotic Personalty of Our Time*, New York, 1937.
id. New Ways in Psychoanalysis. New York, 1939.
30. Allport, G. W., Bruner, J. S., and Jandorf, E. M., Personality Under Social Catastrophe: Ninety Life-Histories of the Nazi Revolution. *Character and Personality*, 10:1-22, 1941.
Allport, G. W., *Personality: A Psychological Interpretation*. New York, 1937.
31. MacIver, R. M., *Community*, London, 1936 (3rd ed.)
32. Devereux, Schizophrenia, *op. cit.*
33. Merton, R. K., The Sociology of Knowledge. *Isis*, 27:493-503, 1937.
id. Karl Mannheim and the Sociology of Knowledge. *Journal of Liberal Religion*, Vol. II, No. 3, Winter, 1941.
34. Schilder, The analysis of Ideologies, *op. cit.*
35. Dembo, T., & Hanfmann, E., The Value of an Orientation Letter for the Newly-Admitted Patient. *Psychiatric Quarterly*, 8:703-721, 1934.
36. Rowland, H., Interaction Processes in a State Mental Hospital. *Psychiatry*, 1:323-337, 1938.
37. Neustatter, W. L., & Freeman, H., Prevention of Fear in Cardiazol Therapy. *Lancet*, 237-1071, 1939.
38. Angyal, A., *Foundations for a Science of Personality*, New York, 1941.
39. Rowland, H., op. cit. *id.* Segregated Communities and Mental Health. *American Association for the Advancement of Science*, "*Mental Health*" (Publication No. 9), pp. 263-268, 1939, *id.* Friendship Patterns in a State Mental Hospital. *Psychiatry*, 2: 363-373, 1939.
40. Rowland, *op. cit.*
41. Rowland, H., *op. cit.*
42. Rowland, *op. cit.*
43. Linton, R., *The Study of Man*, New York, 1936. *id.* A Neglected Aspect of Social Organization. *American Journal of Sociology*, 45:870-886, 1940.
Parsons, T., An Analytical Approach to the Theory of Social Stratification. *American Journal of Sociology*, 45:841-862, 1940.
Davis, K., Mental Hygiene and the Class Structure. *Psychiatry*, 1:55-65, 1938.
44. Merton, R. K., Bureaucratic Structure and Personality. *Social Forces* 18:1-9, 1940.
45. Parsons, T., The Professions and Social Structure. *Social Forces*, 17:457-467, 1939. *id.* An Analytical Approach, *op. cit.*
46. Blackman, N., *op. cit.*
47. Linton, *op. cit.* Parsons, *op. cit.* Mowrer, O. H., Authoritarianism vs. "Self-Government" in the Management of Children's Aggressive (Anti-Social) Reactions as a Preparation for Citizenship in a Democracy. *Journal of Social Psychology, S. P. S. S. I. Bulletin*, 10:121-126, 1939.

48. James, W., *Psychology,* (Briefer Course).
49. Horney, K., New Ways, *op. cit.*
50. Cooley, C. H., *Human Nature and the Social Order,* New York, 1902.
Mead, G. H., *Mind, Self and Society,* Chicago, 1934.
51. Devereux, G., Functioning Units in Ha(rhn)de:a(ng) Society. *Primitive Man,* 10: 1-7, 1937.
52. Cardozo, B., *The Nature of the Judicial Process,* New Haven, 1921.
id. The Growth of the Law, New Haven, 1924.
53. Mannheim, K., *Ideology and Utopia,* New York, 1936. Merton, R. K., Karl Mannheim, and the Sociology of Knowledge. *op. cit.*
54. Russell, B., *Principles of Mathematics* (2nd ed.) New York, 1938.
55. Cf. Lenzen, V. F., Statistical Truth in Physical Science. *University of California Publications in Philosophy,* 10:119-140, 1928.
56. Cf. Devereux, G., A Conceptual Scheme of Society. *American Journal of Sociology,* 45:687-706, 1940.
57. Thomas, W. I., The Behavior Pattern and the Situation. *Publications of the American Sociological Society,* 22:1-13, 1928. *id. Primitive Behavior,* New York, 1937.
58. Park, R. E., News as a Form of Knowledge. *American Journal of Sociology,* 45: 669-686, 1940. The distinction is based on James, W., *The Principles of Psychology,* New York, 1896.
59. Parsons, *op. cit.*
60. Allport, G. W., Personality, *op. cit.*
61. Devereux, Schizophrenia, *op. cit.*
62. Rowland, *op. cit.*
63. Mowrer, O. H., A Stimulus-Response Analysis of Anxiety and its Role as a Reinforcing Agent. *Psychological Review,* 46:553-565, 1939.
64. Rowland, Friendship, *op. cit.*
65. Rowland, Interaction, *op. cit. id.* Friendship, *op. cit.*
66. Devereux, G., Social Structure and the Economy of Affective Bonds. *Psychoanalytic Review,* 29:303-314, 1942.
Freud, S., Mourning and Melancholia. *Collected Papers,* IV:152-170, London, 1925.

TRAUMATIC INJURY OF THE BRAIN CAUSED BY MINUTE SPLINTERS

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The progress of military technique brings about, of necessity, a change in the types of injuries and clinical characteristics of wounds and other traumata. During the current war, one should, therefore, consider as an important task of Soviet medicine the study of new forms of traumatic injuries associated with the special types of modern weapons. I would like to call the attention of the medical world to a specific type of injury which I am describing here for the first time during the present war. I have in mind brain injuries caused by minute shell splinters. I will begin with a short report of a case which was first to suggest to me a new category of injuries.

A Red Army soldier was admitted to our hospital. He suffered from a great number of small and apparently insignificant skull injuries, but his general condition was very serious and manifested itself in headaches, some deafness, and general weakness. All the external seemingly superficial wounds healed quickly, and the bandages were soon removed. But the condition of the patient continued to be just as serious as before: there was deafness, apathy, inertia, and complete exhaustion. These symptoms which were observed previously remained unchanged. The neuropathologist could find no symptoms of an organic injury to the brain. Symptoms of hysteria were also absent. The attending physicians at first thought that the patient received simultaneously both wounds and contusions, but the appropriate treatment (hypertonic solutions, etc.) was of no avail. The patient remained in the same condition, the seriousness of which was out of proportion to the wounds received. Therefore, the opinion was expressed that a psychic exaggeration was possible in this case. When I was consulted, and checked on the patient, I corroborated the presence of a marked adynamia, exhaustion, the apathetic-abulic syndrome, and some deafness. Basic neurological symptoms as well as those of hysteria were absent. Only vasomotor lability was noticed. Psychopathological symptoms of the "exogenous" type, with-

out a doubt, indicated the presence of an organic brain injury. Hence I discarded the suggestion that it might be an emotional overplay, and I asked for a careful X-ray examination.

The X-rays revealed very interesting findings. It seemed that there were a few minute splinters lodged in the brain. The apparently superficial head wounds were obviously portals of entrance for these splinters, and judging by the number of injuries (about twenty) the number of splinters which entered the brain was greater than was shown by X-rays. The splinters were found in the forehead and temporal regions, between the grey and white matter. In view of the fact that the majority of the splinters were not disclosed by the X-rays, it was not possible to form an opinion about localization of all injuries, since local symptoms were absent.

Later I observed more than ten similar cases. One of these cases showed also pains in the facial muscles and blindness of the left eye, in addition to deafness, apathy, abulia, marked adynamia and exhaustion. Scars of numerous small injuries which had healed a long time previously were noticeable not only on the scalp but also on the face. X-rays showed the presence of small splinters in the brain and in the facial muscles. Though the X-rays disclosed nothing in the eye, the ophthalmoscopic examination revealed the presence of metallic dust in the eye. The latter finding proved once more that X-rays disclose only the larger splinters and that the number of minute splinters and particles of metallic dust which penetrate into the brain and other organs may be much greater than those seen in the X-ray pictures.

The physicians in one of the hospitals, where I called attention to the cases of brain injuries caused by minute splinters, pointed out that the findings I presented explained also some other cases of brain injury as well as injuries to other parts of the body. These cases were puzzling at first. I was shown a patient who had the whole upper part of his back covered as in smallpox with numerous scars of small wounds which had healed some time ago. Yet the patient was still in a serious condition. He could hardly move; he complained of pain in his muscles, bones and joints; he had pains in his chest, and a severe cough. For some time this patient was suspected of malingering, since there was an apparent disproportion between his complaints and the objective findings. Later there were found abscesses in his lungs and X-rays disclosed the presence of minute splinters in his muscles, joints, and lungs. It was obvious that the above-mentioned, apparently quite insignificant wounds on his

back served as portals of entrance for the splinters. Later I saw two more analogous cases.

Thus it is to be considered that this type of injury caused by minute splinters has not only a neuro-psychiatric importance, but also a general medical significance, since such injuries may occur in all parts of the body. However, brain injuries where small splinters pierce the skull and coverings must be considered as the most characteristic ones for the given type of injuries. The peculiar nature of the injuries discussed in this paper lies clinically in the fact that such traumata, while formally belonging to brain injuries, have no distinctive symptoms of the usual injuries. They are not accompanied by distinct neurological signs, but they reveal processes belonging to general brain reactions, similar to the closed skull traumata. Therefore, the diagnosis of the given type is mainly based on psychopathological data, which are traceable to the underlying organic condition. That is, we find adynamia, cerebral asthenia (severe exhaustion), the apathetic-abulic syndrome, and deafness. All these symptoms, to which there should be added vasomotor lability, substantially belong to the organically conditioned "exogenous" type of reaction.

However, contrary to the usual exogenous reactions of traumatic origin which have the tendency to be completely or partially reversible and are characterized by a gradual recovery (especially as a result of treatment), the type described here reveals no tendency to recover and persistently shows no improvement for at least one to two months, the period during which we were observing our patients. The malignancy in these cases is due to the fact that the numerous minute splinters are not accessible to surgery. Therefore, the prognosis of these cases must be considered unfavorable. However, some improvement at a later time is not completely excluded, and may be brought about by a spontaneous encapsulation of the splinters. Whether or not such a possibility exists in an individual case can be ascertained only after a prolonged period of observation.

Beside the basic group of cases described, we later made some observations concerning other variants of skull injuries from small splinters.

If among a huge number of small splinters there are one or a few of larger size, then local symptoms are likely to occur (for instance, Jacksonian epilepsy); but at the same time, persistent general brain symptoms are usually manifest—just as is the case in the main variant (deafness, cerebral asthenia, etc.).

Moreover, we observed the following interesting variant: in contrast to the cases where minute splinters shower the skull and penetrate into it through many separate entrances, in this particular variant the minute splinters of an explosive bullet penetrated through one large entrance in a bunch, after the bullet has exploded close to the skull, and fan out in the form of a sheaf inside the brain substance. In this variant there are local symptoms corresponding to the place where the bunch of splinters entered the brain (for instance, hemiparesis) and there are persistent general brain symptoms explainable by the presence of minute splinters spread over the brain (similar to the main variant).

The special clinical character of this form corresponds to its special pathogenesis. This type of injury apparently was not observed during former wars as it depends on the specific properties of the modern weapons. The power of penetration a splinter possesses depends on its mass and on the velocity of movement. It is understandable that small splinters with a low velocity cannot pierce the skull and remain in its exterior coverings. A tremendous increase of velocity is needed to make it possible that these minute splinters, despite their insignificant weight, pierce the skull and the meningeal coverings of the brain and penetrate into the brain substance. This increase of the velocity of movement of the splinters is the only possible explanation for the symptoms described here, symptoms which have manifested themselves for the first time during the current war. This increase of velocity of the splinters explains also several other peculiar characteristics of modern wounds. For instance, cases of fracture of an extremity in the presence of a minute wound were observed which were puzzling at first. Later it turned out that a comparatively small splinter of a shell may fracture a bone, a fact which can be explained only by the extreme velocity of penetration.

Although our series of cases is small and insufficiently followed up (no post-mortem pathological studies were undertaken) nevertheless, we regard it as sufficiently warranted to separate from other brain injuries this special form, caused by minute splinters, which is of a particular nature in pathology and clinical findings. There is no doubt that the appearance of this type of injury during the current war is directly traceable to the specific character of modern weapons.

SEVEN PSYCHOPATHS

A Correlative, Non-statistical Study of Predatory Crime

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Introduction: Methodology in Criminal Psychopathology

In the prosecution of any research work the choice of methodology is often as important as the choice of the problem proper. The history of science records numerous instances of scientific investigations that fell short or even completely failed of their purported aim because of the wrong methodology used. As concerning social and psychological sciences there are, in the main, two methods of approach; namely, the mass and the individual approach. The mass approach, mainly statistical, attempts to extract significance from large data, obtained chiefly without direct participation of the individuals in question, whilst the individual approach attempts to handle the same problem through the study of the individual personalities involved. Whereas the statistical approach uses a large amount of limited data, the individual approach is concerned with fewer cases in which each individual submits much comprehensive data.

Thus, if the subject of recidivism is studied, it is simple enough to take the record of a large number of prisoners and by usual statistical computation figure out the frequency with which recidivism occurs. This, however interesting in itself, would not give us the basic reasons for recidivism, which is the chief justification for the study. If, however, we wish to use the individual approach we may study most carefully and minutely the whole life history of only one or several individuals in which the personal, intimate and psychological reasons for the reaction would be discovered; and the correctness and validity of the conclusions arrived at would be in proportion to the personal elements uncovered. The question, of course, is not which method is the best, but when and under what circumstances is one or the other more suitable.

I

Anyone who has studied even a small number of prisoners will have no difficulty convincing himself that by far the greater number of them, perhaps about 85%, are repeaters. The remaining 15% having been convicted but once. This is about as far as statistics can go. No statistical study, however, can throw the needed light on the important point as to why, out of one hundred men, these eighty-five men and not the others, have been drawn into repeated criminality, and what there is about the other 15% that, after a single offense, saved them from the fate of the others. A careful psychopathologic study of such hundred cases would soon bring to the surface the responsible factors; but that would mean dropping the statistical approach and substituting in lieu thereof, the psychopathological approach.

Or, supposing we wish to study the marital situation among criminals. It is simple enough, of course, to take a list of a thousand or ten thousand prisoners and, by separating the married from the unmarried and divorced, arrive at the conclusion sought. One may continue the study by further separating these into age groups and thus arrive at additional conclusions. All this, however, may give us entirely misleading results for the different and the exceptional are lost in the mass of other data. Thus, in cases of murder we may find perhaps at least two types: the neurotic and psychopathic. The former kills in a deeply emotional setting that is charged with high tension; the psychopathic murderer may be a professional robber who does not hesitate to resort to murder in the course of committing another crime, or he may be a member of a gang that has decided to dispense its own brand of justice and do away with an undesirable member of the same or another gang. Now anyone who has studied these two types of murderers knows that their marital and sex lives are quite different; that of the neurotic approaches more nearly the average and the normal, even if it is often charged with a great deal of emotional tension, while that of the psychopathic murderer is hectic and haphazard, more of the type known as June-and-December, "love-'em-and-leave-'em" attachments. As they do not know the meaning of social or moral responsibility, neither do they know the meaning of family attachment and responsibility, of emotional ties. Now, if we lump all murderers together we can only get an average that smooths out all the differences between the two, thus giving an entirely false picture of the situation.

Likewise, taking an illustration from the purely predatory types of crime, no one will doubt that the obvious cleptomaniac (of which type there are many more than is commonly supposed) is of quite a different personality make-up and different psychogenesis as well, than the predatory psychopath. In the nature of things, statistics can not separate the two; but by lumping them together statistically, we get an entirely different, as well as a false, picture.

Of particular interest here is the problem of so-called sexual crimes. There is no difficulty about placing such a reaction as exhibitionism in the group of sexual crimes, but quite universally such crimes as bigamy, white slavery, violation of the Mann Act, are included in sex crimes. For the most part, however, they do not belong in that category. White slavery is quite universally a predatory crime, the individual white slaver deriving no personal sexual satisfaction from the procedure. Bigamy may have a neurotic as well as a purely psychopathic motive, but lump them together and what you get is an abstract figure that is entirely meaningless. A careful checking up of these cases would send some of them to the group of sexual offenses while others would be included in the group of predatory crimes. To do that, however, it would be necessary to resort to a more careful study of the individual offenders, whereby the entire study would cease to be statistical and would become instead, a study in the psychopathology of crime.

II

Since the purpose of the statistical approach is to extract significance from large masses of data, it can only deal with surface and descriptive phenomena and is, therefore, obliged to rely on surface and descriptive classifications. If it wishes to study types of crime, it must rely upon the conventional legal division of crime into crimes against persons, property, morals and the state. This, however, gives us absolutely no clue to the motivation of the crime. The psychopathologist, on the other hand, with the emphasis on personal factors, would tend to offer a division into psychogenically conditioned and psychopathologically conditioned types of crime. Immediately the conventional classifications fall to pieces, for the psychopathologist would have no difficulty in demonstrating that psychogenetically, murderer A and thief B are brothers under the skin, inasmuch as both were motivated by emotions of revenge, even though their crimes were different. The psychopathologist would also demonstrate that murderer A-1 has more in common

with burglar B-1 than with murderer A, because of like motivation. What is common to A and A-1 is merely the type of crime; what is common to A and B, and A-1 and B-1 is like motivation. The difference in approach will determine a difference in policy. On the basis of law, murder is murder. On the basis of psychopathology, it is the nature of the motivation, that should determine the disposition of the case.

All this, however, is not intended to ignore or belittle the statistical approach. Statistical methods are invaluable in a study of social situations which express large movements. In such a study, for instance, as that of population trends in a given area and a given period, it is evident that no amount of investigation from individual members of the population in question could possibly reveal these trends. Similarly, in the study of certain disease epidemics, no inquiry from individuals who happened to be victims of such epidemics would possibly reveal the general trends. There is no doubt that the statistical approach has its definite place and value. It may even be granted that statistical studies have their certain, though extremely limited, value in the study of crime; but admittedly, such statistical studies have often been overdone, even abused, by applying them to situations which can not possibly yield the desired information. Our journals have literally been cluttered with endless statistical studies that at best give us merely labels without content and usually not only fail to throw light on the subject but actually obscure and confuse the situation. There are certain problems which have often been attacked by the statistical method with very little success because in such problems statistics can do no more than reveal very general trends without revealing the specific causes that are back of these trends. We have studied the distribution of crime, the ages, types, and so forth, without ever approaching anything like an understanding of the basic factors involved. It has required a great deal of effort on the part of statisticians to show by precise mathematical figures the degree of recidivism without, however, revealing the reasons therefor. But students of the subject have long known without statistical corroboration that the majority of adolescent delinquents are slated for a future of crime, and further, they have been able to outline the etiologic factors responsible for such recidivism. It was really not until psychiatrists adapted the individual approach that we began to get any understanding of the situation. We are now beginning to understand many of the reasons for recidivism where no amount of statistical study could suggest even the slightest clue. The time for statistical study of criminality has passed. Our main effort must now be directed toward the

psychological analysis of individual criminals. It is submitted therefore that a correlation of only five cases of criminals studied in great psychological detail is more revelatory of the basic, underlying factors than five thousand cases studied statstically.

As an initial attempt in this direction, I wish to present a correlative analysis of seven cases, each of which has previously been studied in detail, but independent of each other.[1]

I : Background

Heredity
Constitutional Background
Home Environment
Sibling Relationships
Social Environment
Education

Heredity: Hereditary taint is more pronounced in the case of Jerry Biggs than in either Manson or Cleary. There we have a definitely hereditary taint from a maternal grandfather and a mother who became clearly psychotic. In the case of Manson, we have an alcoholic father concerning whose mental habits we know nothing beyond his wife's statement that he "was so eccentric that it would have resulted eventually in his being sent to an institution." In the case of Cleary, we have an irascible and difficult maternal grandfather who was generally disliked, some "wild and reckless" cousins, and a mother whose mental condition is at least open to question.

In the remaining cases the hereditary factor is less noticeable. Fliegelmann's family background yields no known psychopathic determinants, although his mother was presumably neurotic and perhaps a bit paranoid, as was the patient himself. Nothing is known of O'Lone's heredity, but his mother seems to have had some psychopathic tenden-

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(1) These cases are all taken from the author's published two volumes of "Case Studies in the Psychopathology of Crime." They are as follows:
Oscar Fliegelmann, Robbery, Vol. I, Case 1.
Wilbur O'Lone, Forgery, Vol. I, Case 2.
Albert Thornley, Extortion, Impersonation, Vol. I, Case 4.
Harry Dauman, Forgery, Burglary, Vol. I, Case 5.
Walter Manson, Theft of Mail, Vol. II, Case 6.
Atkinson Cleary, White Slavery, Vol. II, Case 7.
Jerry Biggs, Train Robbery, Vol. II, Case 9.

cies. We are likewise without significant informaton with respect to Thornley's heredity; presumably it was clear. One aunt died of tuberculosis. Baumann's father was definitely neurotic, timid and dependent in business and social life, but domineering and inflexible at home. The father also stammered, a difficulty which was presumably passed on to his son in whose early life it became a potential factor in the development of anti-social thoughts and feelings.

Constitutional Background: Constitutionally, Biggs seems to exhibit no noticeable defect. Presumably he was a healthy and outwardly normal child. Manson was "sickly all the time," and had almost all the known diseases of childhood. He had tantrums and fits of rage as a child, even before it became necessary for his mother to put him in an orphanage; and the unwise treatment and spoiling which he received during his periods of illness in childhood seem to have established a pattern of reaction which he exemplified throughout all of his adult life. Cleary tells us that during his first eighteen months he "was very ill and had spasms every other day," this statement being based upon information which he obtained from his mother. From then on, however, he seems to have enjoyed good health.

We do not observe any constitutional factor in the case of Fliegelmann, who was apparently normal and healthy. O'Lone, on the other hand, was the child of aged parents whose perennial difficulties were apparently a matter of common knowledge to the various social agencies. None of the children was normal. The patient possessed an inferior physical make-up and at the age of 27 developed fits which were epileptiform or hysteriform in character. (Although it seems that some of them malingered, most of these seem genuine and one gets the impression that they had a constitutional basis.) Physical privation, malnutrition and general neglect undoubtedly played a not inconsiderable part in this patient's faulty development. Thornley does not seem to present evidence of any constitutional inferiority, alhough the overprotective attitude of his mother may have helped to create a corresponding attitude of dependence on the part of the patient. Baumann, however, was treated as an invalid from the time of his birth, which was premature, and exhibited a retarded development, not entering school until the age of seven, being considered too delicate to play as other children did, and being afflicted with stammering, which increased his difficulties in the field of social adaptability.

Home Environment: In almost every case we find an unsatisfactory home life, and sooner or later a broken home as the result of varying circumstances. The case of Baumann is the only one in which either death, separation, divorce or poverty did not interfere with the maintenance of the home. Biggs' father was absent during most of the time that he could have been of use to his son, and this patient's relationship with his mother was characterized by jealousy, hatred and revenge. Mother hatred is conspicuous in his case as contrasted with the others.

Manson had no remembered contact with his father, and was reared for the most part in an orphan asylum because of his mother's poverty. His attitude toward his mother was characterized by parasitism, indifference and neglect. He neither hated her nor loved her; she could exert no influence over him and he stole from her as readily as from anyone else.

Cleary had a well-meaning but ignorant father with a violent temper, who died when the patient was 14 years old and left him to the mercies of an unstable and possibly psychotic mother and a half-crazy grandfather. If his story about his mother is true, he might have been justified in developing a feeling of resentment toward her and an atittude of indifference and neglect; but he seems always to have preserved a certain fondness for her in spite of her treatment of him, which was perhaps a manifestation of hostility growing out of refused love.

Biggs had the greatest hereditary taint, and it is in his case that the unsatisfactory home environment appears to have exerted the most devastating influence. Just as proper supervision and technical education might have made him a useful citizen, so would a harmonious home have anchored him, we believe, safely in the harbor of respectability. But his first home environment, which seems to have been satisfactory, was ruined by the social ambitions of his near-psychotic mother, who thereafter made their new home a hell for her husband who, in his turn, spent most of his time away from it.

Manson and Cleary would probably have gotten into trouble of some sort in any event, but Cleary at least would not have become a habitual criminal if he had had a proper home, an adequate education and a decent start in life. While Manson's loss of a home at an early age was a factor which might have contributed to his delinquency, it seems more likely, in his case, that the influence of this factor was minmal; that he was so "constitutionally" psychopathic that about the same result could have been expected under almost any circumstances. Both Manson and Cleary were essentially weak, but Manson remained throughout his life an infant in the tantrum stage; and it was in the tan-

trum stage of infancy that the destructive pattern was esablished which he kept on repeating in his adulthood. How much would a good home and a fair education have helped to mitigate his infantile parasitism? We don't know, but we suspect, as already stated, that they would not have been of as much help in his case as in many others. As the facts stand, however, the orphanage bred and encouraged a hostile and aggressive reaction to privation, which landed him in training schools, jails, reformatories, and prisons, where the original difficulty was increased many fold. Drug addiction put the finishing touches on his disintegration, and when that had been successfully conquered, he appears eventually to have replaced it with alcoholism, thus reverting to the hereditary pattern established by his father.

If Cleary's father had lived, and if this patient had never been sent to the reformatory, it is reasonable to suppose that he would have remained honest, unless too much pressure was brought to bear upon him by others. He was impressionable to an abnormal extent and "did everything that was wrong" at the instigation of his associates. But he might have married early, run a farm like his father, and kept on the lawful side of the fence. The home life was characterized by poverty and the social picture by ignorance, and one could not expect much to emerge from either one; but at least the father had the intention to do right, and his continued influence might conceivably have kept the son from doing wrong.

In all three of these cases, however, the broken home or the unsatisfactory home constitutes the first wedge that opened the door to a criminal career. Bigg's parents failed completely in their responsibility; poverty deprived Manson of a home before he was hardly old enough to know what a home meant; Cleary's home life was destroyed when his father died, and he became a victim of the unreasonable antagonism of his mother and his grandfather, two persons who seem to have exhibited a psychotic strain. We might almost say that where there is no home there is and can be no emotional stability; and that where there is no emotional stability we may expect criminal development.

Concerning the other cases, we find that the home life of Fliegelmann was apparently satisfactory, although it was presumably disturbed considerably by his fault-finding mother whose disposition evidently caused the eventual separation between the parents. But the patient was never whipped; the prevailing family reserve allowed for more or less individual development; there seems to have been no particular economic problem; and the patient's early development was to all appear-

ances a fairly normal one. Yet in another and very real sense, there was here also a broken home situation, because of the eventual separation of his parents.

In the case of Thornley, the home, originally intact, was broken up when the mother died, and if we are to credit the patient, the father's disposition underwent a radical change. The home of both Fliegelmann and Thornley were apparently satisfactory, although one must assume that the first was the scene of considerable domestic friction, since the mother is described as shallow, envious, high-tempered and fault-finding, while the parents' differences culminated in divorce. The family reserve which obtained in the case of Fliegelmann probably had much to do with the patient's acute reaction to his first arrest, as a result of which he felt that he could not return home. In neither of these two cases, however, does the home life as such appear to have had any significant relation to the subsequent criminal development.

In contrast with this, the home life of O'Lone was decidedly precarious. In fact, he can almost be said never to have had any. His earliest years with his parents were characterized by impermanence and insecurity; much of his time was spent in an orphanage; and the subsequent attempts first by one parent and then the other to establish some sort of home were generally unsatisfactory. The status of the family itself was doubtful, the actual relations of the parents being a subject of considerable speculation. If O'Lone had ever had a good home that he could call his own, it is doubtful if there would have ever been any criminal history. We may say in his case that the lack of any satisfactory environmental factor was the beginning of all his troubles. His parents were poor; they were already old when he was born; they were well known to the social agencies; they were nomadic and unstable; and the mother's morals were at least open to question. When the patient lived with his parents, or with either of them, the home which he knew was poor and of uncertain duration; the rest of the time he was in an orphanage or a foster home, dependent upon the caprice or the pity of some necessarily disinterested person for the little bit of home-like atmosphere which he could squeeze out of the situation.

The Thornley home appears to have been a satisfactory one through the first sixteen years of the patient's life, or until the death of his mother, from which event is dated the patient's departure from the paths of rectitude. In the cases of both Thornley and Baumann there was an overprotective attitude on the part of the mother. This was further exaggerated (or perhaps we should say capitalized) in Baumann's case by his

own invalidism. All in all, however, the Baumann home appears to have been a satisfactory one; certainly there was nothing about it which tended to anticipate any criminal development on the part of the patient.

In the Baumann case we do not find any broken home, but rather one that remained intact. What is of more significance here is the father's compensatory attitude of domination in the home, as opposed to his timidity outside of it, a factor which must have created considerable domestic tension. The controlling factor, however, is the patient's invalidism, the delicate childhood, the continual doctoring, the constant attention, all constituting a situation in which he was conditioned to helplessness, dependence, and parasitism, as well as one which continually emphasized the ego.

Most of the cases tend to emphasize the desirability of a unified and harmonious home as one of the most important elements in childhood development. Few of these patients had such a home. When Biggs' father wasn't away from home, he and his wife were fighting in the home. Manson can almost be said never to have had a home, for his father died when he was only five years old—following which he was put in an orphanage—and presumably the father was away a good deal of the time during the patient's earliest years. Cleary seems to have had the best home environment, although there was apparently a good deal of friction between his parents and a certain amount of antagonism toward him on the part of his mother; but the little harmony that existed was overshadowed by poverty and hard work.

Sibling Relationship: The subjects' relations with their siblings do not seem to have had much bearing on their development in any of these cases. Biggs hated his only sister. Manson's brother tried to help him, and his sister seems never to have played much of a part in his life. having been brought up for the most part by an aunt. Cleary's brothers and sisters are mentioned only occasionaly in his narrative, and while he speaks as though he were fond of them, it is apparent that his association with them never could have been very close. It is possible that he had some incestuous interest in one sister, but we are not at all sure of this.

Fliegelmann's siblings do not appear to have played any particular part in his life. One sister seems to have been a sort of mother substitute and to have exercised some stabilizing and constructive influence.

O'Lone's attachment to a younger sister seems to have had a lasting effect on his psychosexual development. The influence of his two broth-

ers was apparently negligible, although he did participate in some anti-social behavior with each of them.

Thornley was one of six children. If the patient's narrative is to be relied on, his brothers and sisters played no active part in his life. The children separated after their mother's death, and there is a suggestion that some of them more or less deliberately lost track of the patient, possibly because of his initial anti-social activity which was of a more serious nature that he has chosen to admit.

Baumann was the first of five children, but there is no discussion of the others, probably because he was so self-centered and egotistic that he paid very little attention to them.

Social Environment: None of the patients under discussion was ever surrounded by wealth nor made any claim to social position. They all represent either ordinary middle-class families or definitely poor families. All but two were always city dwellers, and those two spend generally more time in the cities than elsewhere. Biggs was raised on a farm, but the family moved to town. His social milieu was satisfactory enough of itself, but was turned topsy-turvy by his mother's madness. Cleary was born and raised on a farm and spent much time in agricultural communities.

Manson's family was poor, for his mother could not keep the home together after his father died but had to put all three of her children in an orphanage. Socially, the family of O'Lone seems to have been next to slum dwellers. Whatever background they may have once had was already forgotten by the time the patient grew out of infancy into childhood.

Poverty does not seem to have entered into the picture with either Albert Thornley or Harry Baumann. We can not judge of the social picture in either case, for we lack sufficient information, but presumably both patients came from ordinary middle-class families who were well adjusted to their surroundings. In the case of Baumann there is an occasional suggestion of borderline poverty resulting from the father's economic instability; but at certain periods anyway the family situation must have been somewhat better than the average, since we hear of numerous doctors, of the patient's beng taken to school in a carriage, of his attending a private school, etc.

Education: The educaton of Biggs, Manson and Cleary was more or less haphazard, that of Biggs because of his family's indifference; that

of the other two because of poverty and general lack of facilities. We are not told just how much education Fliegelmann had, but presumably it was none too much, since his criminal career began while he was still in his teens. His school adjustment, however, appears to have been normal. O'Lone never finished grammar school, and moved about so much that he had little chance to profit by the meager schooling he could obtain. Thornley probably had some high school education, but we don't know how much, while for Baumann school was a problem from the beginning because of his stammering and other constitutional limitations, and the truancy by which he sought to evade rather than solve his problems was the beginning of his continuing anti-social behavior.

II ETIOLOGY

Onset of Delinquency
The Role of Emotions in the Genesis of Crime
(Privation, Hostility, Parasitism)
Psychogenesis in Criminal Motivation
(Insecurity, Aggression, Hostility, Struggle for Power)
Personality Make-up and Crime

Onset of Delinquency: Delinquency in most cases began early. With Biggs it was motivated partly by hatred and partly by lack of spending money, which his mother consistently refused him. With Manson it seems to have sprung from his infantile parasitism and a general inability to understand the most fundamental laws of property. With Cleary it seems to have been the result of the evil suggestions of others which he had no power to resist. Both Manson and Cleary seem to have exhibited from the first certain defects of reasoning and judgment. For a long while Manson simply didn't seem to have known what "stealing" meant, or to have had any concept of right and wrong where property was involved; and by the time he acquired the requisite knowledge, the emotional reaction was so strongly established that he persisted in theft as a matter of course. Cleary, on the other hand, tells us that he knew that the things he was doing were wrong, but possessed no inclination to do otherwise.

In the case of Fliegelmann the beginning of delinquency was almost imperceptible. It had its inception perhaps in the broken-home situation which left the patient open to the rash suggestions of his associates. His voluntary alienation from his people, following his first arrest for

what was really no more than an unpremeditated prank, was a foreshadowing of his subsequent alienation from society following his arrest for the theft of sacramental wine, an action which was also undertaken in the company of others and under the influence of alcohol, but for which he alone paid the penalty, since he was the only one who was caught. His subsequent criminal activity was indissolubly connected with the idea of vengeance against society.

O'Lone was like Topsy in his criminal career; he "just growed." Placed early in an environment where other children stole and cheated, he naturally saw no reason why he shouldn't do likewise. His early stealing was the inevitable outgrowth of privation, neglect, and lack of supervision.

The beginning of the anti-social behavior of Thornley is shrouded in mystery. His story that he was arrested for spending the night in a mission after finding himself locked in, is clearly minus the core; it is both improbable and unreasonable, particularly in view of the fact that his father thereafter allowed him to be sent to a reformatory. What he actually did, we don't know, but the changed conditions of his home life after his mother's death were undoubtedly the wedge that opened the door to criminal activity.

Thornley and Baumann present a similar situation in that both patients were committed to the reformatory by their fathers, or at least with their fathers' consent. Baumann's initial theft grew out of truancy; to truancy he added theft when he took his father's watch and ran away from home. But his father really set the criminal machinery going when he countenanced the patient's commitment to the reformatory.

The Role of Emotions: Biggs appears to have had a consistent emotional reaction motivated by hate; Manson to have had an infantile emotional reaction very close to the instinctive and characterized by parasitism, lack of judgment, and over-indulgence in sex and drugs; Cleary to have had intermittent or spasmodic reactions of remorse, which, however, were never reinforced by sufficient stability to render them socially effective. Consequently, of these three, Biggs is the only one whose criminality could be called successful, using that term in a strictly relative sense. He was the only one who brought any brain power to his criminal activities and the only one who exhibited a more or less consistent egotistic drive in connection with his criminal career. Neither Manson nor Cleary ever actually planned a crime; if it involved any

daring, the brains behind it belonged to someone else. But the courage and daring of Biggs caused him to be front-page news more than once. Cleary showed more daring than Manson, but always in company with another person, who was the instigator of his activity. When he was left to his own devices, he resorted to sneak-thief tactics—picking pockets, stealing from his employers, encouraging (or compelling) his wife to engage in commercial prostitution—while Manson's highest form of criminal activity was passing bad checks and robbing apartment house mail boxes. Manson is the only one of the three whose criminal behavior was complicated by an artificial element; he was from time to time a drug addict and in his apartment house robberies he was fortified by drugs.

Fliegelmann was motivated by hate also; but it was hate based upon what he regarded as the injustice of society; it was not the deep psychological hatred which motivated Biggs. His hatred was against society which he believed had mistreated and misjudged him, and against the police, who were its symbols of control. Like Biggs, he would not kill, but unlike Biggs he would not even carry a gun. Under sympathetic supervision his hatred became markedly modified. It was decidedly circumstantial and environmental and not rooted in any deep psychogenic soil.

The emotional reaction of O'Lone was essentially childlike. He was forever a little boy in search of a home and a mother, or their equivalents. He has some of the parasitism of Manson, but none of the callousness. If O'Lone could have had a self-sacrificing mother such as Manson's he would not have exhibited any of the indifference to her which Manson exhibited.

The predominant emotional reaction of Thornley was restlessness and dissatisfaction which were derived from his undoubted mother fixato and his grief at his mother's death. Alcohol and drugs complicated the development of his anti-social behavior, the criminal aspects of which are apparently secondary, although his material is suggestive of numerous gaps which may cover more serious offenses than those recorded. In both this case and that of Baumann the emphasis is on the neurotic factors rather than on the criminal activity. Baumann is the parasitic slave of phantasy and his criminality is the fruit of a striving for egoistic compensation, plus a seeming constitutional inability to work hard for what he gets.

Psychogenesis in Criminal Motivations In considering the psycho-

genic factors common to all of these cases, we find first and foremost what may be termed insecurity – an emotional, economic or environmental situation which is threatening the integrity of the indvidual and is productive of restlessness, dissatisfaction, and a general failure of conformity or stabilization. In many cases this results in the development of feelings of hostility which are the seeds of a definite anti-social trend. Cultivated hostility turns into actual aggression in which the individual not only hates society but systematically or sporadically, as the case may be, strikes back at it with the fury of a snake that has been stepped on. And running concurrently with these anti-social manifestations, and sometimes outrunning them, we observe what one might call the struggle for power. In its rudimentary form, this is frequently no more than a strong urge toward self-expression–a striving for individualization. The struggle for power has a varied motivation and may exhibit itself in many ways. In some instances at least, criminality is clearly shown to be a struggle for power, though admittedly by the use of totally unfit means.

Insecurity of one kind or another is present in all seven of these cases–either emotional insecurity or economic insecurity or both. In the case of Biggs it led early to hostility, subsequently to defiant aggression, and finally to a struggle for power, if we assume that his desperate criminal acts were tied up with a positive egotistic drive. Certainly he threw into his crimes all the cunning, skill and energy which, if constructively directed, might have been expected to win him at least some kind of social pre-eminence or economic success.

Manson's economic insecurity was genuine enough, but it may be questioned whether he knew the meaning of emotional insecurity; he was too fundamentally parasitic, too instinctively grasping. He rarely had enough. One might almost question his possession of emotions at all. Whatever emotional insecurity he exhibited was part and parcel of his essential infantilism. Hostility was also instinctive with him, for it was immediately brought into play whenever he was frustrated. But it was fleeting and short-lasting. When his mother denied him money, he developed an instant feeling of hostility against her and forthwith stole from her. Sometimes it was a comparatively mild hostility, however, by which he justified his thefts with the reflection that he needed the money more than the person from whom he stole it. To get was his all-controlling motive and he didn't have to feel hostile in order to steal.

Cleary's insecurity was both emotional and economic, his initial

emotional insecurity being apparently connected with the antagonistic attitude maintained by his mother, while the economic insecurity was the natural heritage of poor farmers forever struggling to make ends meet. Both Manson and Cleary may be said to have cherished feelings of hatred against their environment; but in both cases these feelings were consciously lacking in continuity and their sporadic criminality might be said to represent a struggle for power to the extent that they sought to impress their will on their environment; but neither one had any conception of power in a strictly social sense. Their lives were too much a hand-to-mouth, day-to-day affair, and they were both too deficient in any real egoistic urge. They had a general hatred of society and struck out at it from time to time, but only as occasion or opportunity arose; neither one ever planned anything resembling an emotional anti-social campaign. Neither one was ever constantly and emotionally aware that society was his enemy, as was definitely the case with Biggs, whose whole egoistic drive was diverted from a constructive channel into a groove of intense hate.

To the extent to which a struggle for power may embrace a purely compensatory endeavor, one might say that Cleary expressed something of the sort in his sex life. He had sexual relations with the daughter of a man with whom he was working; with the wife of a friend at whose home he was staying; with the daughter of the people who were traveling by wagon and who took him along with them; and it is stated also that the girl whom he was forced to marry was made pregnant by him at a time when he was working for her father. This continuing pattern of sexual involvement with the very women whom he should have let alone may represent an unconscious means of seeking compensation for occupying an inferior situation, and to that extent some idea of mastery over his environment. The sex life of Manson was altogether too hit-or-miss to warrant a conclusion that it represented any idea of social mastery, but in its tendency toward excess it may have served as a compensation for denials of many of the things he wanted in childhood; or more likely yet, it was expression of strong constitutional need. This is only partly true of Biggs. Sex with him was a thing apart, the mere periodic satisfaction of strong physical desires. Mastery of his environment was, however, a ruling passion with him and closely tied up wth the daring robberies and hair-breadth escapes which made his story read like colorful fiction, in contrast with the sordid and relatively mediocre recitals of Manson and Cleary.

In the case of Fliegelmann emotional insecurity began perhaps with

the friction between his parents which led to their separation; and certainly both emotional and economic insecurity followed his first arrest and his voluntary exile from home. Hostility sprang into existence overnight with his first prison sentence, while his keen sense of injustice and the bitterness occasioned by prison brutality fostered ideas of aggression, which he put into practice as soon as he was free to do so. Emotional insecurity attended the period spent with his family between the time of his parole and the time of his discharge, and it was certainly heightened by his feeling of social ostracism due to his having contracted syphilis. To the extent that he made an egoistic religion out of "getting even" with society for the wrongs he thought it had done him, he may be said to have engaged in a struggle for power. His criminal career was not unlike that of Biggs but on a much smaller scale. He hated society for quite conscious reasons just as Biggs hated it for unconscious reasons. Much of the misdirected energy which characterized Biggs is also present in Fliegelmann. Seeking to make society pay for the wrong it has done him is another way of imposing his will on society and trying to obtain mastery over it. Fliegelmann's voluminous correspondence also exhibited his continuing struggle for power. He was forever putting his best foot foremost, continually seeking to impress others with his virtues and ability to make good.

O'Lone knew almost nothing but emotional and economic insecurity. Driven from his first home by an earthquake, cursed with undependable, eccentric and ageing parents, shunted from pillar to post, from orphanage to foster home to parental establishments under the care of social agencies, there appears to have been no time in his life when he was anything more than part of the flotsam and jetsam of emotional and economic shipwreck. Something essentially childlike in his make-up prevented him from becoming more aggressive than he did. His crimes for the most part resulted from following the line of least resistance. At no time does he appear to exhibit any actual social hatred. Any struggle for power which he exhibited was a rudimentary one indeed; it was a pathetic struggle to secure and maintain something resembling a homelike atmosphere; it was no more than part of the under-dog's struggle for existence.

Thornley was literally overwhelmed with emotional insecurity when his mother died and when his father consented to his being sent to the reformatory. The insecurity coincident with his adventures as a parole violator was both emotional and economic. His periodic suicidal contemplations and at least one suicidal attempt bespeak emotional

insecurity. Economic insecurity pursued him intermittently throughout his career, being often partially the result of his alcoholism.

In his case there was very little indication of a struggle for power. His history is characterized rather by an attempt to escape from his neurotic difficulties, mainly by alcohol, at least once by suicide. His attempt to enlist fraudulently in the Army and his impersonation of an officer in connection with extortion do indicate some attempt on his part to control his environment. In his case anything resembling a struggle for power seems to have been displaced by phantasy. One of the traits commented on by his fellow patients was his expansive boastfulness and obvious lying, a form of compensatory phantasy-building.

Baumann was early conditioned to dependency and parasitism by reason of his retarded development and numerous child illnesses. His case is parallel in some respects with that of Manson. Both patients were apparently spoiled brats, but Baumann came from presumably better parents and had the advantages of a good home for many years, whereas Manson was thrust early by economic necessity into an orphanage.

Baumann, like O'Lone, sought comfort, but he sought it much more aggressively and his very search for it may be said to have constituted something resembling a struggle for power. Unlike Thornley he made positive attempts to realize his phantasies, but the end and aim of his anti-social activities seems to have been to reproduce the condition of protection which surrounded him in childhood.

There was not much active hostility in the case of either Thornley or Baumann, although it seems probable that both of them cherished hostile feelings against their fathers, for in each case the father was responsible for the son's going to the reformatory. In both cases, however, the phantasy-building apparatus was too busy wth dreams of the future to permit of much time being spent in thoughts of revenge for the past.

Personality Make-up and Crime: When we consider the personality make-up of the seven individuals represented in this discussion, there appears to be no outstanding factor which particularly predisposed them towards crime, but frequently we observe personality traits which imposed upon them certain criminal limitations, or which may have predisposed them toward the particular kind of crime in which they engaged. In many cases we are hampered in our estimation of

their respective personality traits by the possession of insufficient data or data of doubtful reliability.

The most outstanding criminal of the group is Biggs, and in him we find also the strongest emotional force – the deepest hate, the greatest courage, and the most persistent egoism. We find in him precisely those qualities which, given a different direction by a different environmental influence, would have produced a successful business man, respected leader of the community, or an aggressive politician. His personality make-up approaches more nearly that of the normal individual than any of the other cases. He was essentially practical and always in touch with his environment, no matter how unpleasant that environment may have been. There was no escape into phantasy where he was concerned. Something in his character imposed a definite limitation on his criminality, however, He would not kill. We believe this to have been associated with the respect and affection which he always felt for his father, just as we believe that a large part of his anti-social attitude was an elaborate projection of the hatred which he always felt for his mother. Crime was a business with him; not a weakness. His weakness was gambling, and at times his outstanding inconsistency was cheating; but always there burned in him the steady fire of hate. Hostility and aggression were instinctive reactions with him.

In marked contrast with him, we find Manson whose personality make-up was simplicity itself. Without conscience, without judgment, without courage, we could expect from him only those crimes of which his history is full – stealing from his mother, stealing from newsboys, stealing from his employers, stealing from his friends; never taking the initiative, and only participating in a crime of any daring in the company of others; succumbing to drugs and alcohol; indulging in sexual excesses to the point of exhaustion; finally killing under the influence of drink, stupidly and without motivation. His hatred was weak; his revenge was weak, his crimes were mean and petty. The only thing that kept him going was his blind appetite, which demanded satisfaction in the easiest and quickest way.

Nor could we expect Cleary to have resorted to anything but secondary and mean crimes. Lack of judgment characterized his early life. He set fire to the barn because he had been having fun watching burning leaves; he allowed his slightly older boy friends to get him drunk; he yielded to the suggestions of others and stole whatever they told him to. And so we find him becoming a "passer" for a counterfeiter, helping a woman to hold up filling stations; and forcing his own wife into

a career of commercial prostitution. He had more courage than Manson, but like Manson's, it was only exhibited under the leadership of someone else. His own purpose in life was mainly to get by the best way he could, which meant the easiest way he could. The motive of vengeance was stronger in him than it was in Manson, and he was more dangerous when crossed. He killed one man, probably in self defense, but also in anger; and only circumstances that involved the passing of time kept him from killing his grandfather. Emotional instability kept him from any constructive planning, made him a drifter, and made him follow, like Manson, the line of least resistance.

When we come to the case of Oscar Fliegelmann, we find again a personality more nearly resembling the normal and consequently an individual capable of planning his crimes, more after the manner of Biggs. The feeling of hate was strong in both of them, but more deeply psychogenically conditioned (that is, deep seated) in Biggs and more immediately environmentally conditioned in Fliegelmann. In the passing of time and certain ameliorating circumstances seemed to have worn it down; in the former it seemed to go on forever. Fliegelmann's hatred was directed solely against society because of the injustice which he considered it had done him; and was occasioned by reactions largely within the field of consciousness; Biggs' hatred went deeper and had a more persistent unconscious motivation. But he had the practical bent of Biggs; there is not much phantasy in him. There was a predisposition toward hysteria, however, and his reaction to imprisonment was an hysterical one, as was also Cleary's, whereas Biggs reacted in a strictly practical manner, either by attempting to escape, by going on a hunger strike, or by loading the warden with endless abuse.

With the case of O'Lone we commence the procession of phantasy boys. He, Thornley and Baumann were all endowed with the apparatus of phantasy building which played a greater or lesser part in their crimes. All three were typicaly neurotic, all three striving forever to compensate for something they didn't have or had lost – O'Lone for the home he never knew; Thornley for the mother who had died; Baumann for the excessive protection which had surrounded him as a sick child. O'Lone possessed neither courage, judgment or intelligence, relatively speaking; and his crimes were stupid and childish. Thornley's crimes were more mixed up with phantasy than O'Lone's, while Baumann's were nearly all dictated by phantasy. The latter had enough intelligence to anticipate some of his real crimes and render them apparently irresponsible by preceding them with premeditated absurdi-

ties. To this extent he possessed more intelligence than the other two, but none of the practical or normal intelligence of either Biggs or Fliegelmann. Neither O'Lone, Thornley nor Baumann evinced any of the deep hate of Biggs or Fliegemann, nor were their crimes motivated by revenge, at least never in the same sense as those of the other two.

Of all seven cases Manson's is the only one in which criminal activity strikes us as being inevitable. In none of the others do we see a personality make-up which necessarily or inevitably was a prelude to crime; in all of them we can visualize a different set of circumstances, some other combination of environmental factors which might have saved the day. In the case of the greatest criminal of them all, we are most sorrowfully confronted with the social error of his misdirected energies. Psychiatric aid at the right time could have affected, we believe, all the difference between commendable accomplishment and hopeless waste. But Manson cannot be pictured by any stretch of the imagination as anything but anti-social and criminal, for he seems to have been basically lacking any of the elements which would have made a successful citizen. But criminal he would have been in spite of everything, for he lived on instinct and pristine instinct is anti-social. Cradled in the lap of luxury no less than in that of poverty, the result would have been the same, different perhaps in kind, but not fundamentally different.

III Sex Life

The sex life of some of the men presents certan contrasts and contradictions. Biggs, who was the greatest criminal, was the only one who made a good husband. Manson's marriage was short-lived and terminated in desertion; and Cleary's marriage resulted in turning his wife into a prostitute, which was the cause of his being sent to prison. His wife subsequently obtained a divorce. Biggs, the only good husband, is also the only one whose history includes numerous homosexual episodes; but his homosexuality was purely facultative in character, because of confinement to reformatories and prisons. Manson had one early episode of homosexual frustration, which culminated in an attack on his love-object with a knife; but his attraction to the other boy was based entrely on psychological identification – this boy reminded him of a particular girl. Later, in a mental hospital, he submitted to active fellatio by other patients in order to obtain sexual gratification. Cleary appears never to have had any homosexual activity, both according to his direct statement and the events recited in his narrative; but he does

have a few homosexual dreams, indicating the presence of a homosexual component which, however, seems never to have been a source of trouble to him.

The sex life of Fliegelmann was complicated, and ruined, by syphilis. This disease contributed materially to his criminality, for it increased his feelings of disgrace and social ostracism, lowered his sense of social responsibility, and also accentuated his feelings of revenge. He himself regarded it as a turning point in his life, and it was the precursor of steady moral deterioration.

Presumably O'Lone was bisexual, although we are without any definite homosexual history. The general impression conveyed is that he was under-sexed, sex desire in itself being altogether subsidiary to his search for some emotional satisfaction represented by dependency, a homelike atmosphere, and mother or sister substitutes. Sex seems to have little or no bearing on his anti-social behavior.

Thornley is a typical example of mother fixation, and his sexual experiences all bear the earmarks of disguised and derivates of incest. His sex life, as a part of his general neurotic development, undoubtedly contributed to his social instability, but does not appear to have had any direct bearing on his criminal acts.

Baumann exemplified greatly retarded sexual development. He was twenty-three years old before he knew the facts of life. His narrative leads us to believe that he was definitely subnormal from a sexual standpoint. He is somewhat comparable with O'Lone in that comfort, a home, protection, etc., far overbalance any erotic attractions, but of the two, O'Lone had a comparatively greater sexual drive. Baumann's sexual activity seems to have involved neither love nor much physical desire. His libido appears to have been largely absorbed by his ego, and the latter to have sought only to reproduce dependence of childhood.

LV. ABNORMALITIES OF BEHAVIOR

Gambling
Alcohol and Drugs
Suicidal Trends
Homicidal Reactions

Gambling: Gambling is hardly mentioned in Clearly's narrative. In the story of Manson we find it discussed at some length in connection with jealousy and representing apparently only one outstanding episode.

In the case of Biggs, however, gambling plays an important part – not only gambling but cheating. He twice became a deserter from the Army on account of being ostracized because of his cheating, and on more than one occasion a protracted perod of gambling was a prelude to a daring robbery. In his case gambling undoubtedly had a psychological connection with his other anti-social behavior and constitutes a strong link in the chain of his criminality.

The other four cases do not show much gambling. It is not mentioned by Fliegelamnn. O'Lone talked about it, but one of his associates insisted that this was all phantasy–that he couldn't play at all. Thornley does not mention it in his narrative, but it is presumed that gambling, along with alcohol was with him another means of neurotic escape from the tension created by his difficulties. Gambling didn't fit into the infantile and parisitic pictures presented by Baumann. In all of these four cases it may be described as either negligible or as an incidental factor.

Alcohol and Drugs: Alcohol is a negligible factor in the Biggs case. We hear next to nothing about it. Manson had an alcoholic father and the last thinng we hear of him years after leaving St. Elizabeths is the killing of his common-law wife while under the influence of liquor; but in the history which we have before us drugs are the demoralizing element, and while we read once in a while of his being drunk, there is no alcoholic continuity. Nor does alcohol play any appreciable part in the story of Cleary. That he did drink we have no doubt whatever, for he tells of stealing whiskey and of selling whiskey illegally, and says that the only two occasions on which he experienced passive fellatio he was drunk; but there is nothing to indicate that alcohol was ever a problem with him. In none of these three cases, therefore, can the crimes of the patients under discussion be traced to alcohol. Manson's drug addiction has some connection with his crimes, but criminal activity in his case began long before he became acquainted with drugs.

In the case of Fliegelmann alcohol is a somewhat prominent factor. Drinking to some extent preceded imprisonment and increased markedly following the contraction of syphilis. It is inextricably tied up with the crime for which he was first sent to prison, for he was drunk at the time, and the crime itself consisted in stealing sacramental wine from a Catholic church. Basically, however, he was not an alcoholic.

Alcohol plays a negligible part in the case of O'Lone. It was an occasional escape from unpleasant reality and an occasional sexual stimulant.

Both alcohol and drugs appear in the case of Thornley and were undoubtedly connected with his criminal activity, for he seems to have resorted to them not only as means of escape from unhappiness but also as a means of fortifying his courage prior to the commission of some antisocial act.

It is doubtful whether either alcohol or drugs ever entered into the picture in the case of Baumann, although the patient seems to have talked about both, giving them as excuses for some of his difficulties. It is his egoism and his parasitism plus his phantasy-building ability from which stems his criminal behavior, but neither alcohol nor drugs had any part in it.

Suicidal Trends: Suicide, or at least suicidal contemplations, figure in some of the cases. Biggs never contemplated suicide and only threatened it in prison when he was driven to desperation by the harsh treatment meted out to him as punishment for his attempts to escape; but it was he who finally did commit suicide sometime after his release from prison. Suicide to him was the last word in egoistic defeat. Manson made one suicidal attempt with gas, and one suicidal gesture at a high window, but never betrayed any strong or consistent suicidal urge. The first attempt grew out of his desertion by a girl with whom he had been having protracted sexual relations and the contemplated suicide at the high window resulted from his actual suffering while undergoing treatment for drug addiction.

Cleary made a suicidal attempt at the age of twelve, which appears to have been connected with his emotional attitude toward his mother; and another during his second term in prison, when he presumably was psychotic. He also made a suicidal gesture while in prison, which he admits was purely for effect, and intended to influence his return to St. Elizabeths (which it did). Suicide with Manson and Cleary appears to have been a part of their general emotional instability, while with Biggs it approaches more nearly the attitude held by the average man, who looks upon it only as a last resort in what seems to be an utterly hopeless situation.

There is no mention of any suicidal trend in connection with Fliegelman. O'Lone made an impulsive suicidal attempt, and probably a half-hearted, if not an altogether theatrical one.

Suicide in the case of Thornley, was like alcohol, an attempt at an escape from seemingly intolerable situations. There is an indefinite history of a suicide pact with a girl about which he claims to have an alco-

holic amnesia. The girl at least committed suicide as a result of which he found himself in a hospital in the custody of police, having been admitted as a case of bichloride poisoning. Suicidal contemplation played a recurring role in his unhappy life.

Baumann had no suicidal urge. He was too busily occupied gratifying his infantile ego and trying to duplicate the protective situation of his invalid childhood.

Homicidal Reactions: Of the cases, Cleary is the only one whose narrative contains a history of murder; and this murder was purely accidental in character and apparently a matter of self-defense. However, Cleary's history contains an account of several moods of vengeance when he had a definitely murderous intent and might very well have committed murder if circumstances had not kept his intended victims out of his way until the first force of his anger had subsided.

Manson's attack on another boy while in the orphanage might have resulted seriously, but can not be considered as the act of a potential murderer; although in one of the several reformatories where he was confined he also sharpened a knife which he intended to use on a boy who had gotten the better of him in a fight. This incident is similar to the one in Cleary's prison history. After Manson had been discharged from St. Elizabeths, however, and had been manifesting improvement for some time, he killed his common-law wife while under the influence of alcohol, for which crime, when last heard of, he was serving a prison sentence.

None of the other cases exhibited any homicidal tendency. Fliegelmann refused to carry a gun. O'Lone and Baumann were both too parasitic and generally dependent to even think of homicide, and Thornley was much too unhappy. Suicide, not homicide, was nearer to his inclination.

V: Diagnosis

Mental Abnormalities
Psychopathy: True or False

Mental Abnormality: With respect to the question of mental abnormality, it may be affirmed, of course, that all of these patients were mentally ill; that mental illness constituted the whole fabric of their essentially unhappy, if not miserable, lives; but this is not the same as maintaining that all of them were insane in the legally or commonly accepted

understanding of that term. Biggs did not exhibit at any time any actual psychotic symptoms. His was a particular type of neurosis characterized chiefly by predatory aggression, perhaps as a reaction to rejection and insecurity. Manson was the most abnormal of the three. His most conspicuous reaction was the use of drugs, which in itself, however, was only a part of a deeper abnormality that was responsible for his anti-social and criminal behavior. After being in prison for a little less than two years, following his arrest for the mail box thefts, he developed what appeared to be a mild prison psychosis which disappeared shortly after his admission to St. Elizabeths. But his psychotic disturbance appears to have been definitely connected with his imprisonment, as was that of Cleary. Neither of these patients exhibited any marked symptoms after they had been at St. Elizabeths for a short time. Cleary recovered so far as to be able to return to prison, and there had another disturbance characterized by one genuine and one malingered suicidal attempt. Following his second transfer to St. Elizabeths, he got along satisfactorily until his sentence expired and he was discharged. In Cleary's case, however, the alternating period of over-activity and depression suggested the possibility of Manic-Depressive Psychosis, or at least of a cyclothymic personality.

Manson is in a class by himself. He is neither the cyclothymic personality, represented by Cleary, nor the aggressive neurotic represented by Biggs. He is a crystal pure psychopath of the passive parasitic type.

With respect to the remaining four cases, it appears that for all their psychopathic behavior, they suffered from varying types of neuroses and that their mental difficulties were all emotionally and environmentally conditioned. Fliegelmann appears to have a history of certain genuine hysterical reactions which he later drew upon for the purpose of malingering a psychotic disturbance. Hysterical malingering also plays some part in the cases of O'Lone and Baumann, suggesting that a neurotic disturbance is the fundamental difficulty with both of these patients. The first malingered convulsions and the second amnesia. As contrasted with Fliegelmann, O'Lone appears to have had a more constitutional pre-disposition toward mental illness—a poor heredity aided and abetted by a sordid environment—and this also applies when he is contrasted with Baumann. Emotional reactions to privation and denial appear to have been responsible for many of the traits of O'Lone which border on the psychopathic—his extreme selfishness, the seizing of petty advantages, hoarding, etc.

Thornley is another neurotic, given to excessive phantasy and seeking escape from his difficulties in alcohol and drugs. The emotional insecurity which he experienced following his mother's death may well have been the starting point of all his difficulties, accentuated by the fact that his father failed to take his mother's place.

Superficially, Baumann is the "craziest" of these four cases, and there seems to be no doubt that some of his amnesia attacks were genuine, although these were in the minority when contrasted with the number which he malingered. His whole history, however, appears to have been a continuous compensatory activity based on inferiority and insecurity and a desire to reproduce the situation of irresponsible dependence which obtained when he was a childhood invalid, as well as to gratify his egoistic phantasies of possessing the means to render such situation practicable.

Psychopathy: True or False: Every one of these cases has gone through a number of institutions and in every one of these institutions authorities have slapped on the paitent the label, "Psychopathic Personality." In doing so they have followed the line of least resistance quite as much as most of the patients. Their reasoning was simple: The patient has broken the law; the patient has been in the reformatory or in prison; ergo, the patient is a psychopath.

With more detailed historical material available and more careful analysis of the subject, it becomes quite clear that of the seven cases represented here exactly one and only one is a true and genuine psychopath. Manson is a psychopath. There can be very little doubt about it. Not all the king's horses nor all the king's men, in the present stage of psychiatric knowledge, can make him anything else. From the beginning he has shown himself to be impervious to affective influence, impervious to teaching or experience, possessed of a never-ending gift of grab, without conscience, without honor, without insight, and without common sense.

This, however, is not true of any of the other six, all of whom show in one way or another a conditioned affect as the basis for anti-social behavior, each of whom demonstrates, in one way or another, that he is the victim of a neurotic disturbance, and that his criminality, even when it reaches the proportions of a business (as it does in the case of Jerry Biggs and to a lesser extent in the case of Oscar Fliegelmann) springs from distorted emotional drives and is defensive or compensatory in character; in other words, it is *motivational*. One prison sentence does

not make a psychopath any more than one swallow makes a summer; but while it might be added that many swallows are evidence of summer, it can not similarly be adduced that many prison terms are evidence of psychopathy. Psychopathy is not a matter of externals; it is rather a matter of the psychic make-up, a particular set of attitudes, a mode of handling life situations. A man who hates society because he believes that it has done him wrong (and there are many times when, legal findings to the contrary notwithstanding, it *has* done him wrong) may nevertheless be reconciled to society when it approaches with sympathy and understanding, and as a result may change his mental attitude; but sympathy and understanding are wasted on the psychopath, who did not hate society because he thought it had done him wrong but whose inborn nature it was to get from his environment whatever he could and all he could at all times and under all circumstances. Jerry Biggs could have been made a decent member of society; Oscar Fliegelmann's social attitude was influenced to some extent as a result of the psychotherapeutic treatment he received at St. Elizabeths. Wilbur O'Lone would have forgotten all about crime the moment he had been given a good home and found someone to take an honest, kindly interest in him. Thornley and Baumann were both the victims of a deeper neurotic disturbance, and it would be more difficult to visualize for them a crime-free future, although it is believed that, with protracted and careful therapeutic training, they too could have been delivered from the escape and compensatory drives which impelled them in an anti-social direction. But the fact remains that the crimes which they would have committed would still have been a symptom of their respective neuroses.

Nothing deters the true psychopath in his foolish search for gratification of one kind or another. He has no conscience to impose any inhibition on him, and he is without the fear or the forethought that is born of past experience. Manson cared not a damn whether the family had food in the house so long as he could find his mother's pocketbook and steal enough to take him to a show. He had no gratitude toward his brother who had gotten him a job, but promptly discredited his brother and lost the job when he was impelled to yield to a foolish and dangerous caprice and free the venereally infected women in the hospital. He would stupidly and treacherously have killed a fellow prisoner who had gotten the better of him in a fight, if the knife which he manufactured for this purpose had not been found on him, and he did stupidly and treacherously kill his common-law wife under the influence of alcohol.

He set no bounds to his indulgence, but pursued sex and drugs and liquor to the point of exhaustion, hallucination and insensibility.

As opposed to this, we find Jerry Biggs definitely drawing the line at murder and Oscar Fliegelmann refusing to carry a gun. We find the former living for a period of years honestly and respectably, and the latter torn with anxiety because of the fact that he had brought disgrace on his family. We find Atkinson Cleary reacting with acute hysterical illness to his commitment to the reformatory, whereas the numerous reformatory and prison sentences of Manson were as so much water on a duck's back. We find Wilbur O'Lone doing impulsively generous things for the girl who had deserted him to marry another man, and Albert Thornley frequently contemplating suicide. In his selfishness, Baumann approaches a step nearer the psychopathic pattern, but we observe at once that he is the victim of exaggerated neurotic phantasies of greatness, and egoism that is entirely the result of frustration, privation and humiliation; *emphasizing once more that in the consideration of any behavior, what is important is not the outward reaction, but the motivation back of it.*

In all of these cases there is an emotional drive—the search for security, the satisfaction of the ego, or the struggle for power, or the thirst for revenge—which underlies the anti-social behavior; but in the case of the true psychopath we have instinctive anti-social behavior which is without any motive except that associated with constitutional acquisitiveness and aggression. Manson had no reason at any time to hate anyone, nor did he actually hate anyone, but all of his activity was injurious to himself because he had no control over it and could set no limit to his indulgence. His only motive was to get—anything he could, from anyone he could, in any way he could; and no aspect of this motive was too small or too mean or too trivial or too treacherous to offer any obstruction to its operation. No one can imagine any one of the other six patients stealing change from a newsboy, or showing his spite by defecating in someone's bed. These were psychopathic actions *per se*, which exhibited a complete lack of inhibition or self-respect.

"Getting into trouble" is not, therefore, the yardstick by which psychopathy must be measured. Neurotics get into trouble; so do psychotics, so do normal people for that matter. But the neurotics and the psychotics have a reason for doing so, a poor reason or a crazy reason, but a reason based upon some emotional and ideational pattern. The psychopath has neither reason nor emotion; what passes for reason with him is empty and what passes for emotion is shallow. His reasons and his emo-

tions are no more than weak and obviously insufficient excuses for doing what he is, as it were, predestined to do because of the apparently constitutional make-up which underlies his psychopathic behavior.

VI: TREATMENT

Imprisonment—A Deterrent or a Contributor to Crime: In a majority of these cases we observe the malignant and devastating influence of the reformatory—truly one of society's most potent contributions to crime. In two cases the patient was sent to the reformatory by his own mother; in two others by his own father. In the Biggs case this was the result of selfish indifferences and criminal negligence. In the Cleary case we are uncertain just how much his mother had do with it. Manson's mother would never have sent him to a reformatory, and he was not in her custody when he was sent there. In all three reformatories which figured in the first three cases there was initiation into homosexuality, education in crime, and sadistic brutality. All three of these institutions were a disgrace to civilization, and represent a standing condemnation of social and legislative indifference. In the Cleary case we have an account of a murder committed by an infuriated drill master, with a resulting legislative investigation which was about as productive of results as such investigations usually are. In each of the three institutions something constructive might have been done; but everything that was done was destructive. The prison conditions described by the first three patients are also open to much criticism, but they do not arouse the indignation excited by the reformatory conditions because by the time these patients reached prison they were thoroughly immersed in crime. Had the conditions which obtained in the respective reformatories been different, none of the three might ever have seen a prison. A good deal of recidivism is due less to the incorrigibility of individual criminals than to the unintelligent way society handles their problems.

The circumstances which preceded Thornley's commitment to the reformatory are shrouded in mystery; we only know that his father did not intervene. We are not given many details of the conditions which obtained at this institution, but the emphasis is on the poor judgment exercised in placing him during his parole periods. We only know that the prevailing atmosphere was one of fear; that the minds of most of the oth-

er boys were filled with sex and crime; that the instructor was an alcoholic.

Baumann was actually sent to the reformatory by his father, whose watch he had stolen. His reformatory experience, however, was considerably better than that of the others, perhaps because his essentially childlike nature saved him from many contacts he would otherwise have had; perhaps because it was after all a better organized institution than any of the others. The fact remains that he returned home somewhat improved. The institution had given scientific attention to his stammering and he emerged cured of that defect. Of all these cases, his is the only one in which a reformatory residence seems to have done any good at all.

Fleigelmann did not go to a reformatory, but had more than one jail sentence preceding his first imprisonment. In prison, brutality and torture were the rule; and the treatment which he received and witnessed contributed materially to his increasing anti-social hatred and to his determination to get even as soon as he was released. His first jail sentence and his first imprisonment were social and judicial errors of judgment which paved the way for a criminal career. Had the situations then existing been considered intelligently, it is doubtful whether the motives of hatred and revenge would ever have projected this patient into criminal activity. Certainly in his case imprisonment was a cause of crime; not a cure.

The reformatory did not play any part in the case of O'Lone until he was twenty-three years old and had already been in the Army overseas. His year's residence was not a particularly disagreeable period, for he was able to show off before and lord it over younger fellows. His influence over them was presumably worse than their over him. The reformatory experience, however had no deterring effect on his subsequent anti-social behavior, for soon after his release he stole a government check. In connection with the reformatory, he does mention harsh treatment which "only made the inmates revengeful," but we do not hear that he himself suffered to any appreciable extent.

In only one case out of six, therefore, do we learn of the reformatory having actually done even the least bit of good (and even in that case it did not good in so far as arresting the development of the patient's criminal activity is concerned); and in the other cases we see it as a sordid, ugly blot on the story of social control.

SUMMARY AND CONCLUSIONS

There are commonly current many opinions about criminality which, on closer analysis, reveal themselves as pure prejudices, preconceptions, and misconceptions based on inadequate knowledge as well as distortion of facts. This is well illustrated by the definite analysis of seven cases presented here and studied in detail.

1. In the matter of studying crime, psychiatry has followed, in the main, the methodology of sociology and psychology, using the statistical and mass approach. Such approach has been found to be entirely sterile and unenlightening, it being gradually replaced by the psychopathological approach that emphasizes individual psychogenesis and the dynamic operation of mechanisms and processes.

2. Criminality is not a single, homogenous entity but contains many diversified elements due to a great variety of factors. It is, therefore, best to speak of criminalities rather than criminality.

3. Limiting ourselves in this study to predatory crimes ,it is shown here that beyond the common characteristic of predation these individuals are as different from each other as any seven individuals could possibly be.

4. A study of these cases explodes the notion that criminality is born in the man. In none of the cases studied can it be said with any definiteness that their criminality is traceable entirely or even largely, to bad heredity. Even when heredity appears to be quite tainted, no direct correlation can be established between heredity and criminal behavior. In population at large one finds many instances of equally bad heredity that, however, expressed itself in other forms than criminality.

5. Criminals are neither powerful giants who abuse their strength by preying upon the unsuspecting public, nor are they weaklings who, unable on account of their physical condition to make a normal adjustment, resort instead to crime. They are found among criminals all sorts of physiques which, in themselves, have no direct bearing on crime.

6. Criminals do not all come from slums and lower classes but from all classes and states of society, from poor homes as well as from good homes that are comfortably situated. Low classes furnish larger num-

bers because there are more poor people in the world than rich. Their education is not significantly different from the level of society in which they grew up. What is common, however, to many of them is a broken home situation. Rarely does a criminal come from a harmonious home, with well adjusted parents and good parent-child and sibling relationship. With but one exception, in none was criminality inevitable. The one exception is to be found in the small but quite well defined group commonly designated as psychopaths (primary or idiopathic type). Individuals belonging to this group live entirely at the instinctual animal level and do not appear to be influenced by the quality of the home and generous emotions lavished upon them, though even here, given a superior environment, much can be done to mitigate or lessen the character of the anti-social behavior.

7. Quite universally and almost without exception the etiological factors behind criminal behavior are discovered to be in the emotional life of the individuals concerned. Particularly significant are

attempts to re-enact phantasies

privations that are not neutralized by adequate compensatory measures or outlets

anguishing feelings of emotional insecurity, without substantial defenses against it, or

a searching for a home which they never had

by creating flows of hostility not sufficiently neutralized by such positive and generous emotions as love, affection, tenderness; such hostility leading to aggression expressing itself in criminal acts, and all revealing itself as attempts to control the environments, leading in some cases to obvious struggle for power.

Because of the fact that they are affectively conditioned, they represent particular types of neuroses.

8. As neuroses, they have the variety of components usually found in neuroses, except that the basic emotional reactions are more in the direction of conditioned hate or unrequited privation than conditioned love. This explodes another popular fallacy which, without clinical basis, assumes that criminals do not have a super-ego at all, or at best only an impaired one. This is comparable to the statement that an individual with a cyclothymic makeup has no super-ego or has an impaired super-ego because in the course of a manic attack he cheated, robbed or mur-

dered. In such instance, the super-ego is not absent or impaired but has been pushed back because of the pressure of instinct as expressed by excitement. Likewise, criminals, it is shown, do have a super-ego, often an unusually sensitive one, only the super-ego is kept in abeyance and check by the pressure of instinctual forces which demand immediate gratification.

9. No specific personality make-up that may be regarded as criminal has emerged from this study. There are brave and daring men among them, as there are cowards and weaklings, practical men and realists, as well as dreamers and phantaseurs; some blame society and others for their troubles, others are consumed and anguished by feelings of guilt.

10. As if to explode another popular fallacy, the sex life of criminals varies from excess to marked undersexing, just as we find in the population at large. Perversions are found here and there but not in a significant degree. Where it exists, it is often of a facultative character due to privation in prison. Significant in the presence of unconscious determinants such as observed in promiscuity behind which may be found an incestuous drive.

11. Another common misconception concerns gambling, alcoholism, and drug addiction. Criminals are not all gamblers and alcoholics. Only one case was a drug addict; only one other was a gambler with whom gambling was a passion. One or two drank, but were not in the true sense alcoholics. The rest are virtually free from these vices.

12. That some of the cases entertained strong suicidal notions is a revealing finding but it is not so surprising when one views them as neurotics among whom suicides and suicidal contemplations are common enough. More revealing yet is the fact that all but one escaped and avoided committing murder.

13. Viewed in a diagnostic perspective, all but one are revealed as suffering from neuroses environmentally conditioned; neuroses of privation or hostility, leading to criminality, as an overt manifestation. Only one of these cases can properly and with sufficient justification be put in the group of psychopathies. It may, therefore, be said that the psychopaths furnish but a relatively small proportion of predatory criminality.

14. As one reviews, in retrospect, not only what the criminal has done to society but what society has done for and to the criminal, the conclusion is inescapable that society is responsible to a very large extent for their criminality. Most of the cases of criminality are produced in a setting of emotional privation and hostility. The obvious, sensible, rational therapeutic procedure would be to relieve privation and neutralize the hostility. Instead, we aggravate the situation and strengthen these factors by placing the offenders in confinement, thus adding more yet to privation and heightening the hostility with the inevitable result that criminality is strengthened and structuralized into a chronic form of behavior. Hospitals, not jails; psychotherapy and not brutilizing punishments are seen here as the one hope of redeeming the criminal and redeeming society that has produced the criminal.

THE USE OF THE GOODENOUGH TEST FOR REVEALING MALE HOMOSEXUALITY

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In recent years the Goodenough Drawing a Man Test[7] has been used for many purposes other than the measurement of the intelligence of children. It has been used for adults as well as for children to indicate disturbances of the body schema due to organic and mental disorders.[1 4 5 6] It is suitable for all types of subjects and can be given individually or in groups. Patients usually complete their drawings in less than five minutes, and if desired can be quickly scored according to the method standardized by Goodenough. In the use of this test with adult prisoners it was noted that many known homosexuals would draw a man with noticeable feminine characteristics. This fact suggested its use to reveal cases of undetected homosexuality and possibly even latent homosexuality.

It was the purpose of this study to investigate whether drawing a man with feminine characteristics was of appreciable significance in the detection of male homosexuality. From a collection of 801 drawings, many of which showed some degree of femininity, sixteen considered to be definitely feminine and sixteen considered to be definite masculine were selected for this preliminary paper by observers who had no knowledge of the subjects.** The drawings with feminine characteristics are shown in Plates I, II, III and IV, and those with masculine characteristics on Plates Ia, IIa, IIIa and IVa. The case history records of the thirty-two subjects who made the drawings were then examined for evidences of homosexual behavior. Following are short summaries of the pertinent data in this regard.

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* From the Medical Center for Federal Prisoners, Springfield, Missouri.

** A detailed study involving a large number of feminine drawings is contemplated.

CASE MATERIAL

Feminine Group (See Plates I, II, III, IV)

Case No. 1 Age 27, White, Average Intelligence. Sex History: Marked homosexuality, Prefers passive role. Effeminate, small testicles, sex infantilism with obesity, smooth skin, light beard, large breasts, large pelvis, plump thighs, soft spoken, girlish mannerisms, cheeks flushed, soft eyes. Quote "I have always loved a nice lady and longed to be a woman. I always wanted men to love me."

Case No. 2 Age 20, White, Average Intelligence. Sex History: Known homosexual. States first homosexual seduction occurred after arrest for present offense. Fellatio. Has engaged in herterosexual acts. Unmarried. Wishes to be cured of homosexuality.

Case No. 3 Age 19, White, Average Intelligence. Sex History: Homosexual since age 12. Female impersonator and has been kept by men. When arrested had curling iron, lipstick, rouge, powder and mascara in his possession.

Case No. 4 Age 40, Negro, Borderline Intelligence. Sex History: Army sodomy case. Definite homosexual. Female role both orally and anally. Very effeminate: laughs, giggles. and has a feminine build.

Case No. 5 Age 20, Negro, Dull Normal Intelligence. Sex History: Army sodomy case. History of homosexual behavior. Assumes female role both orally and anally; prefers latter. No sexual attraction to women. In only heterosexual affair was impotent.

Case No. 6 Age 27, White, Mental Defective. Sex History: Quote "I bummed around a lot in childhood." Easily led by bad companions. Married twice, one child. Convicted of rape prior to this offense. (Homosexuality not suspected.)

Case No. 7 Age 36, Porto Rican, Borderline Intelligence. Sex History: Homosexuality not confirmed. Unmarried. Contracted both syphilis and gonorrhea in 1934. Claims strong heterosexual interests. (Homosexuality not suspected.)

Case No. 8 Age 28, White, Very Superior Intelligence. Sex History: Homosexuality admitted by subject. Develops strong homosexual attachments.

Case No. 9 Age 19, White, Average Intelligence. Sex History: Homosexual attachment to another inmate. Caught in love affair–hugging and kissing.

Case No. 10 Age 27, White, Superior Intelligence. Sex History: Homosexuality confirmed by inmate's statements. Has written numerous poems describing his homosexual attachments to fellow inmates. Also has written a very creditable paper on detection of homosexuality in a prison environment.

Case No. 11 Age 32, White, Average Intelligence. Sex History: Has no record of homosexuality. Left home at age 13 with unnamed proctor to work on road camp. Married, separated many times, and divorced. Promiscuous with women. Chronic alcoholism. Admits being approached on one occasion by homosexual who attempted intimacies. (Homosexuality not suspected.)

Case No. 12 Age 31, White, Average Intelligence. Sex History: Army sodomy case. Admits numerous homosexual experiences since age 14.

Case No. 13 Age 25, White, Average Intelligence. Sex History: Admits homosexuality. Known homosexual for many years. Passive sodomy at age 7. A true invert, feminine build, gait, and speech. Preferred dolls in childhood. Female impersonator.

Case No. 14 Age 18, White, Borderline Intelligence. Sex History: Denies heterosexual experiences. Admits one homosexual act at age 16. Stayed away from home at night frequently as an adolescent and if broke would find a 'friend.'

Case No. 15 Age 18, White, Average Intelligence. Sex History: Admits homosexuality an abnormal sex practices since early age. Ran away from home at age 11 and stayed away many days at a time. Feminine role in sodomy. Effeminate appearance and mannerisms.

Case No. 16 Age 27, Negro, Dull Normal Intelligence. Sex History: Army Sodomy case. Admits homosexual activities. Feminine traits in speech, dress and mannerisms. Prefers active sodomy.

Case Material

Masculine Group (See Plates Ia, IIa, IIIa, IVa)

Case No. 17 Age 22, Negro, Borderline Intelligence. Sex History: Married, one child. No evidence of homosexual behavior.

Case No. 18 Age 31, White, Bright Normal Intelligence. Sex History: Married a divorcee 8 years his senior who had 3 children by a previous husband. No evidence of homosexual behavior.

Case No. 19 Age 19, Indian, Mental Defective. Sex History: Convicted of attempted rape. No evidence of homosexual behavior.

Case No. 20 Age 40, White, Superior Intelligence. Sex History: Married, one son. No evidences of homosexual behavior.

Case No. 21 Age 30, White, Bright normal Intelligence. Sex History: Denies homosexuality. No evidences of homosexuality.

Case No. 22 Age 45, White, Very Superior Intelligence. Sex History: Unstable marital history, 3 children. Divorce for promiscuity. No evidence of homosexual behavior.

Case No. 23 Age 21, White, Average Intelligence. Sex History: Unmarried. No evidences of homosexual behavior.

Case No. 24 Age 34, White, Bright Normal Intelligence. Sex History: Denies Homosexuality. No evidences of homosexual behavior.

Case No. 25 Age 23, White, Superior Intelligence. Sex History: No evidences of homosexual behavior.

Case No. 62 Age 26, White, Average Intelligence. Sex History: Single. Strong heterosexual interest. No evidences of homosexual behavior.

Case No. 27 Age 39, Indian, Mental Defective. Sex History: Rape of a six year old girl. Anonymous letter says "He is an immoral degenerate, who bothers boys to compel immoral acts with boys by threats." (Suspected of homosexual behavior.)

Case No. 28 Age 30, White, Average Intelligence. Sex History: Married 9 years. No evidences of homsexual behavior.

Case No. 29 Age 34, White, Borderline Intelligence. Sex History: History of two homosexual experiences. Psycho-sexual arrest on the homosexual level.

Case No. 30 Age 20, Negro, Dull Normal Intelligence. Sex History: Married, 2 children. No evidences of homosexual behavior.

Case No. 31 Age 22, White, Average Intelligence. Sex History: No evidences of homosexual behavior.

Case No. 32 Age 26, White, Bright Normal Intelligence. Sex History: Married; good maritial relationship. No evidences of homosexual behavior.

TABLE NO. I

SUMMARY OF CASE MATERIAL

	Feminine Group	*Masculine Group*
Homosexuality Confirmed	13	1
Homosexuality Suspected	0	1
Homosexuality Not Suspected	3	14
Total	16	16

DISCUSSION

Graphic art has been used in various ways in studying the psychology of normal and abnormal behavior of both children and adults. Bender[8] [3] believes that "art presents an opportunity to express instinctual impulses in a form socially acceptable, and can reveal the fantasies

and unconscious life of a child not only to himself but to the psychiatrist." Bender[1] states that "the drawing of a child is an experiment in the visual motor interpretation of the integrated pattern of the kinesthetic, motor, cutaneous and visual impression." In accordance with this formulation, Fingert, Kagan, and Schilder[5] say "we can, therefore, regard the Goodenough Test as an expression of total organization which incorporates not only technical abilities, but also total tendencies." Bender[1] relates that in the drawing of a man there is a specific apperception of the body image. She states that: "The body image is built up as a maturation process by a gestalt integration of all sensory, motor and social experiences of the child." Furthermore, she has said[2] "there is a concept of the body image that is socially determined. One sees and otherwise experiences the body image of other people. There are many variations in the body types, but one becomes acquainted with these and in one way or another identifies himself with them so that they become a part of one's own composite body image." In the light of these statements the Goodenough Test would appear to be an excellent tool for permitting a projection of inner dynamic tendencies.

The findings of this study have shown that many sex-deviates will actually project their inner homosexual tendencies in their pictorial representations of the male adult human figure. This is particularly true for homosexuals, since many of them tend to live at an immature emotional level, and therefore like children are more apt to project in a graphic manner these inner tendencies than wuold more matured subjects.

Some of the most common feminine characteristics revealed by our collection of drawings were: large eyes with details such as brow, lashes and pupils; "Cupid's bow" mouth; delicate nose; curved figure; small hands and feet; and graceful posturing. In contrast the masculine drawings most often showed less prominent eyes with less eye detail, large mouth with few curves, large nose, angular figure, large stubby hands and feet, and obvious masculine posturing.

Some means of detecting active and latent homosexual tendencies is sorely needed. This need is obvious in prisons. In the armed forces the problem of homosexuality is constantly encountered. Our armed forces could be relieved of considerable expense and trouble if these individuals could be screened out prior to induction. It is of interest to note that cases 4, 5, 12 and 16 in our feminine group were Army sodomy cases and conceivably could have been rejected from the Army if they

had produced such drawings as these at the induction station.* Moreover, through experience it has been found that even slightly feminine drawings may indicate the presence of a strong feminine component within the personality structure. This fact might be used to advantage by psychiatrists to reveal those cases where maladjustment is due to a conflict growing out of unrecognized homosexual tendencies. Also the use of the Goodenough Test might even be extended by the making of a study to see whether homosexually inclined women would impart masculinity to their drawings of a female figure.

Our experience has shown that not all known male homosexuals will produce drawings of a man with feminine characteristics, but in those cases in which these traits are revealed it is a very significant indication of a personality structure in which a strong feminine component is present.

SUMMARY

This paper describes the use of the Goodenough Test (Drawing of a Man) for revealing male homosexuality. Two sets of drawings were presented, sixteen of the feminine type and sixteen of the masculine type. The search of the records revealed a high incidence of overt homosexuality in the feminine group as contrasted with a low incidence in the masculine group. Out of the 16 cases in the feminine group, homosexuality was definitely confirmed in 13 cases, suspected in no cases, and not suspected in 3 cases. In contrast, out of the 16 cases comprising the masculine group, homosexuality was definitely confirmed in one case, suspected in one case, and not suspected in 14 cases. Although it was found that not all known homosexuals would project feminine characteristics in their drawings of a man, it was discovered that whenever one encounters a male subject who draws a man with feminine characteristics it is a highly significant indication of a strong feminine component in the personality structure.

* In an unselected group of 36 Army sodomy cases it was found that nineteen (53%) showed feminine characteristics in their drawings of a man. Thirteen (36%) drawings were strongly feminine, six (17%) were noticeably feminine, ten (28%) were masculine and seven (19%) were of a primitive neuter type.

REFERENCES

1. Bender, Lauretta. The Goodenough Test (drawing a man) in chronic encephalitis in children. *J. Nerv. and Ment. Dis.*, 1940, 91, 277-286.
2. Bender, Lauretta. Psychoses associated with somatic diseases that distort the body structure. *Arch. Neur. and Psychiat.*, 1934, 32, 1000-1029.
3. Bender, Lauretta. Art and therapy in the mental disturbance of children. *J. Nerv. and Ment. Dis.*, 1937, 86, 249-263.
4. Earl, C. J. The human figure drawings of adult defectives. *J. Ment. Sci.*, 1933, 79, 305-327.
5. Fingert, H. H., Kagan, J. R., Schilder, P. The Goodenough Test in insulin and metrazol treatment of schizophrenia. *J. Gen. Psychol.*, 1939, 21, 349-365.
6. Geil, G. A. Wechsler-Bellevue and Goodenough Test score patterns for psychopaths, schizophrenics and non-schizophrenic psychotics. Sixth Progress report of the psychopathic unit. Medical Center for Federal Prisoners, Springfield, Missouri, 1942, 79-107.
7. Goodenough, Florence. Measurement of intelligence by drawings. New York World Book, 1926.
8. Zimmerman, J. & Garfinkle, I. Preliminary study of art productions of the adult psychotic. *Psychiatric Quarterly*, 1942, 16, 313-318.

PLATE I. *Drawings of a Man made by Feminine Group*
(Cases 1 to 4)

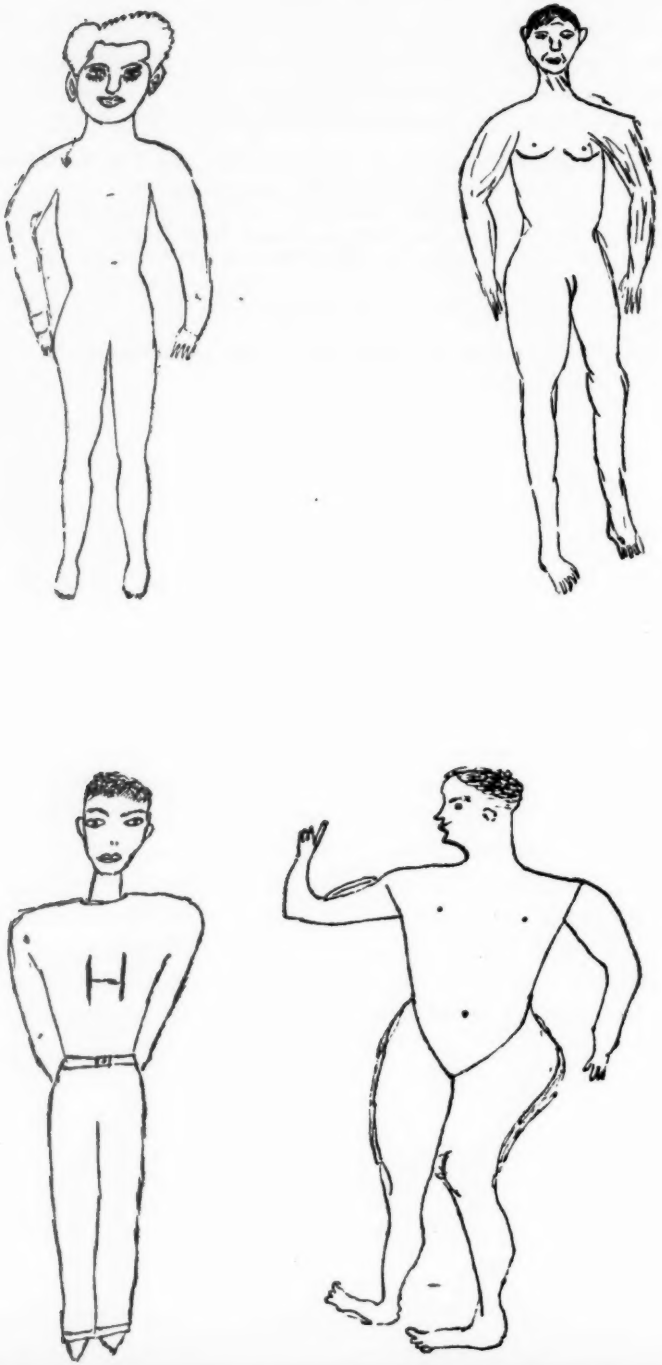


PLATE Ia. *Drawings of a Man made by Masculine Group*
(Cases 17 to 20)

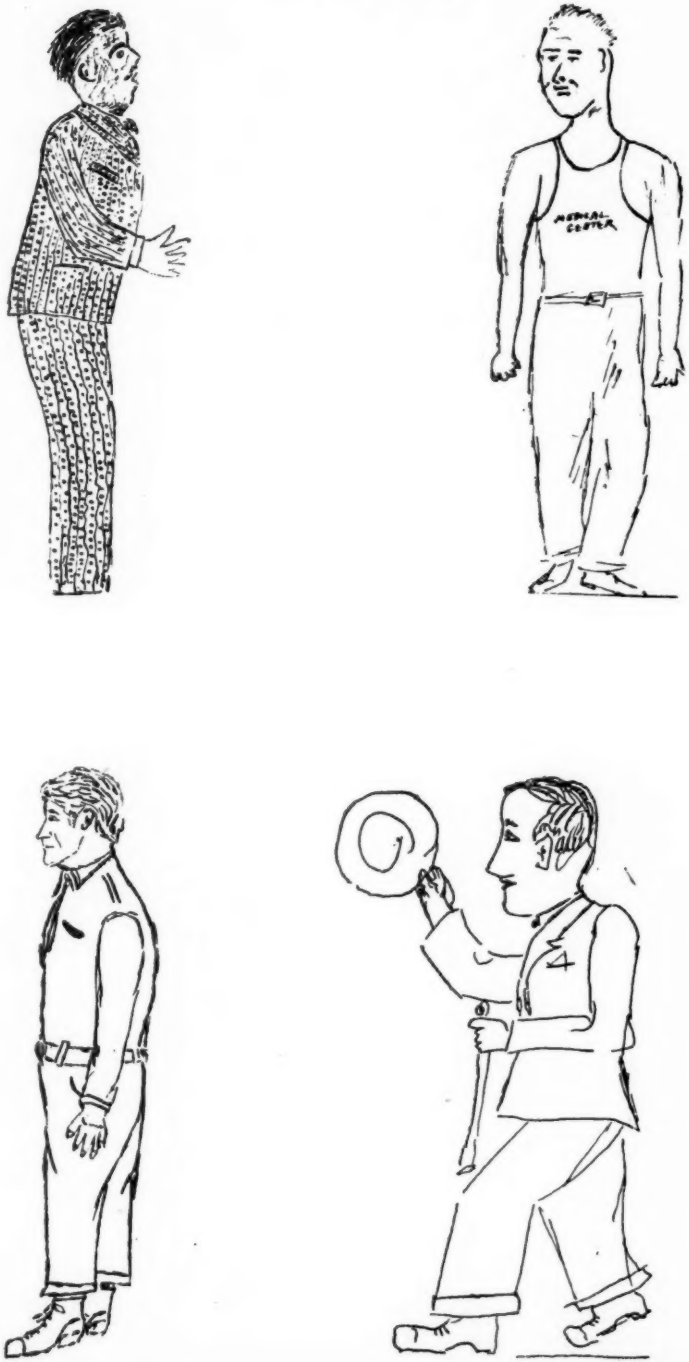
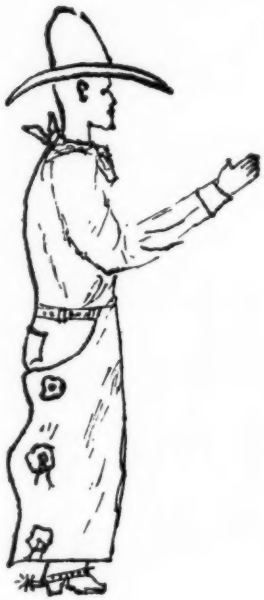


PLATE II. *Drawings of a Man made by Feminine Group*
(Cases 5 to 8)

PLATE IIa. *Drawings of a Man made by Masculine Group*
(Cases 21 to 24)



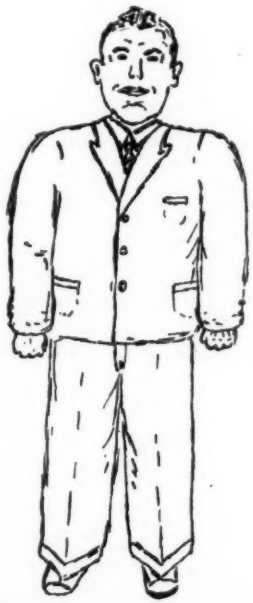
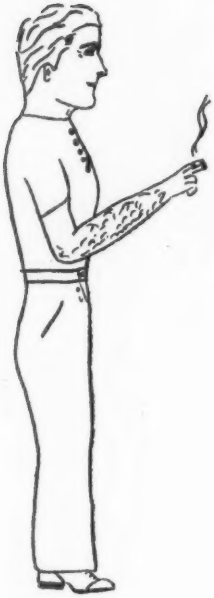


PLATE III. *Drawings of a Man made by Feminine Group*
(Cases 9 to 12)



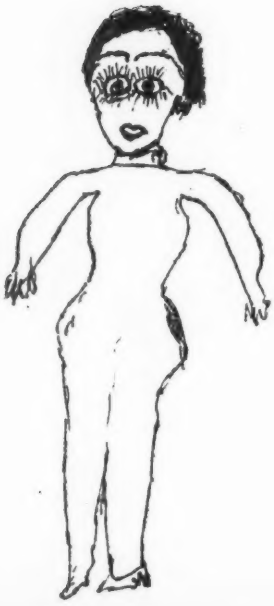


PLATE IIIa. *Drawings of a Man made by Masculine Group*
(Cases 25 to 28)

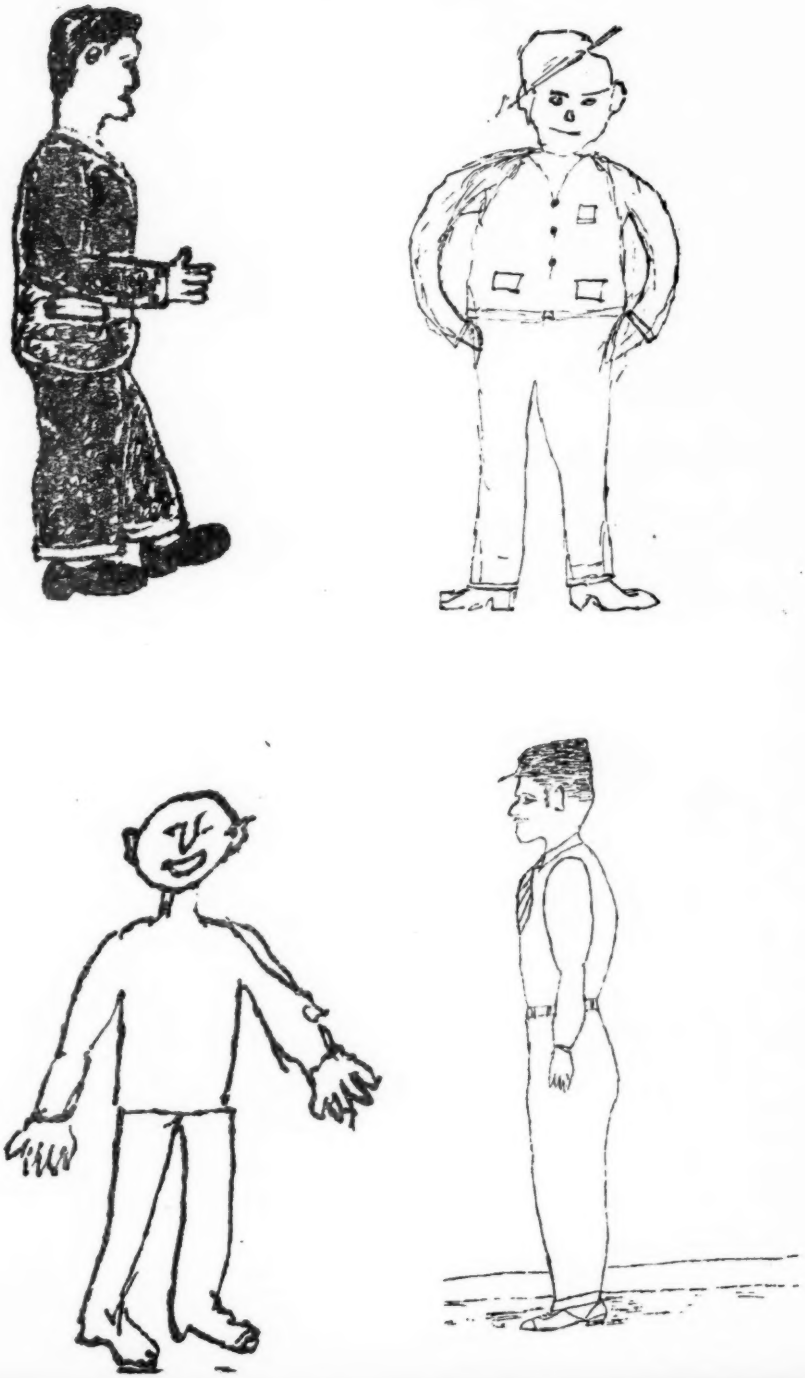


PLATE IV. *Drawings of a Man made by Feminine Group*
(Cases 13 to 16)

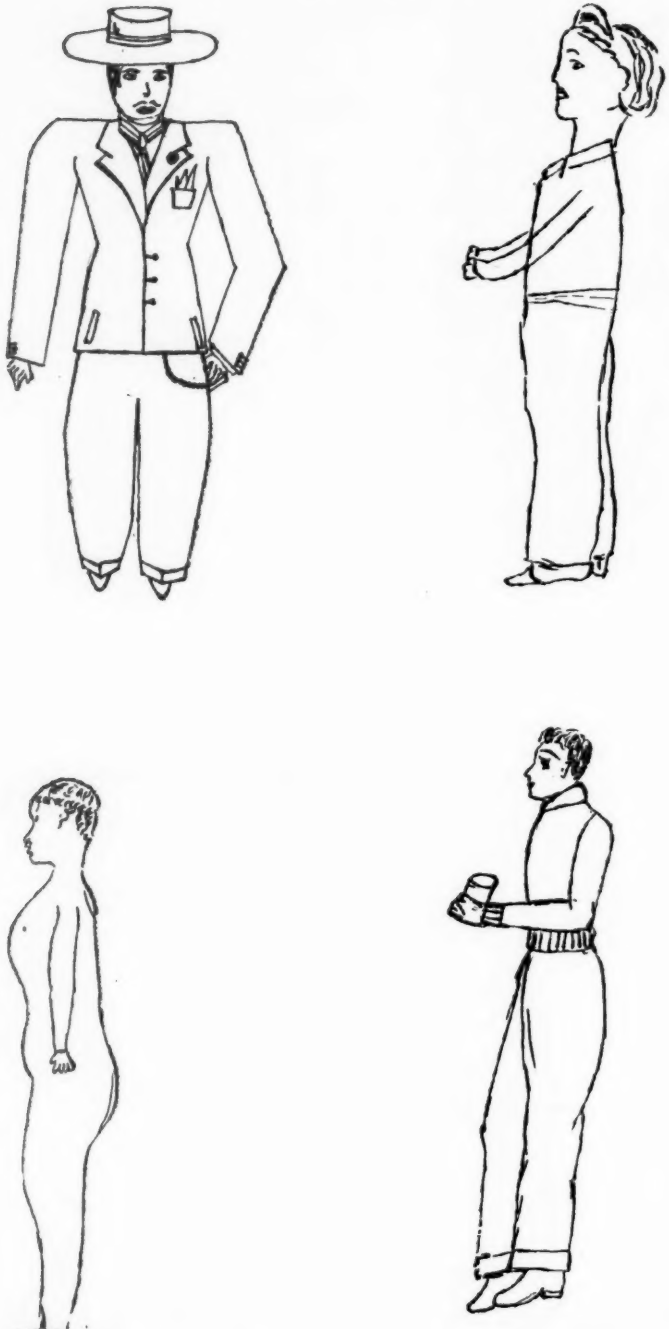


PLATE IVa. *Drawings of a Man made by Masculine Group*
(Cases 29 to 32)

UNDERSTANDING THE ALCOHOL PATIENT

PART I

The Practical Use of Projective Techniques

(A) The Rorschach Analysis

(B) The Thematic Apperception Test

(C) Other Techniques

(A) *The Rorschach Analysis as a New Approach in Understanding and Treating the Alcohol Patient.* *

VICTORIA CRANFORD**
and
ROBERT V. SELIGER***

Before discussing the Rorschach Analysis as a helpful, new approach in understanding and treating the alcohol patient, a few preliminary references must be made about this technique itself and the man whose name it bears.

Hermann Rorschach, whom Bleuler called "the hope of an entire generation of Swiss psychiatry," was born in Zurich in 1884. Thirty-seven years later, in 1922, he died of peritonitis—only a short time after publication of his monograph, *Psychodiagnostik*, source-book for all workers in this field.

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* Read at the Institute on Alcoholism held in Baltimore, Maryland, September 14, 1944, sponsored by The National Committee on Alcohol Hygiene, Inc. and the Baltimore Committee. This was not an Institute for patients, but one for the instruction of the *educators* of the present and post war period—the medical profession, social workers, teachers, the clergy, the Red Cross, veterans rehabilitation workers, the courts, the probation department of the judiciary and probation system, workers in criminology and the sociological community-minded citizenry.

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His father had been an art teacher, and his early death forced Rorschach to earn his living instead of continuing his studies in natural science. A friend suggested he study medicine; and so, instead of being another Darwin, perhaps, the world was given Hermann Rorschach and his great contribution to psychiatry and the understanding of human beings—the Rorschach Diagnostic Analysis, or, the "inkblot test of personality."

Rorschach spent eleven years investigating the scientific use of inkblots, first stumbled upon by Justinius Kerner, a German psychologist, in 1857. Kerner had noticed that accidental inkblots, such as any of us might make, tended to take on various forms and shapes which impressed him with the possibility of being given bizarre significance. He made and later published some inkblots, using them as a way of testing *imagination.* Later, Alfred Binet, the famous French psychologist, who perfected the so-called I. Q. test, thought that selected inkblots might be used as a method of testing certain personality *traits,* for it had been observed that when shown the same blot, certain types of individuals tended to see the same or similar pictures.

Various psychologists continued these experiments, but it was not until Hermann Rorschach's investigations in this field that any technique for diagnostic use with psychiatric illnesses and personality disorders was developed on a scientific basis of theory that was tested and retested in clinical practice to benefit by medical psychiatric knowledge. After much experimentation, Rorschach selected and standardized ten inkblot "pictures" universally used by all Rorchach workers. They measure 7x9½ inches, and are photographs of the originals, which were made by a procedure similar to that of dropping ink on a piece of paper, folding it in half and pressing down so that the ink spreads out in different shapes. When unfolded, this meaningless picture has certain visible objective and structural features which make it look as though "it might be something." Carefully chosen from hundreds of trial inkblots, the Rorschach plates embody specific life-situations (the easy, the difficult, the threatening and so on). One by one, they are shown an individual, who tells what they look like. Afterwards, properly using the Rorschach method of interpretation, we can tell what *he* looks like as a person.

In the last twenty-three years since its findings were first made public, the Rorschach technique has become an establishd method of indirectly analyzing personality structures and diagnosing certain psychiatric illnesses. Here and abroad, in research and practical clinical work, it has benefitted further from additional testing and retesting of

its results and checking them with clinical facts. Practically, it is used as a diagnostic tool, as a way of "x-raying a personality," as an aid in therapy and placement. A Rorschach analysis indicates whether or not a patient has organic brain damage, which may not yet be shown by other tests or by his behavior. It is also a means of determining how much progress has been made during treatment. Often, a Rorschach analysis will reveal deeply hidden anxieties and conflicts which even very skillful psychotherapeutic probing will not bring to the surface until after many many interviews.

As a new approach in understanding the alcohol patient, in addition to the above, this analysis also helps in making plans for "where" and "how" to treat an individual, with the goal of total permanent abstinence for life, and of personality rehabilitation and re-education, that is, learning how to live contentedly and productively without using alcohol, the drug and narcotic. We use this technique to supplement a formal psychiatric examination, which includes a complete life-history, facts about the drinking problem and behavior, a neurological and mental status survey and other indicated tests and procedures.

As we are all aware, many people do not, themselves, know why they drink. When sober, they are rarely conscious of disturbing physical or emotional difficulties, and are, therfore, unlike patients with other psychiatric or medical problems, who have definite complaints: "I can't sleep." "I have such terrible headaches." "I don't feel good." "I have a pain here." – and who, although they may not be able to say *why*, most certainly can and do tell the physician *what* ails them.

Of course, various "reasons" for excessive drinking are often given: a nagging wife, an misunderstanding husband, a cranky boss, specific worries, illness or injury. These "reasons" are, however, factors in–not causes of–the alcohol problem. Biographical and other evidence, when supplied, invariably shows that the roots of drinking–a need to escape or to be narcotized, lie in early childhood personality reactions to the environmental climate and subsequent faulty development in interpersonal relationships of sentiments, attitudes and resulting *behavior patterns*. Under various stimuli, "explosions" may occur; or there may be a more or less continuous smouldering.

A Rorschach analysis will reveal all these and other drives and tensions and so aid in handling the patient with tact and firmness, solidly based on objective knowledge of *who* he is, what are his deep sentiments and attitudes, and how best to help alter, or modify, these mechanisms and emotional values and goals in life so that the individual will no long-

er need so urgently to narcotize himself. It will indicate his ways of "dodging issues" – of unconsciously covering up, as well as the depth and breadth of his social interpersonal relationships–of prime importance in a sound and wholesome adjustment to life. How he reacts to danger, to authority, to anxiety-producing and other usual and unusual situations is shown. Whether he has too many or too few "hobbies" for a well-functioning, practical way of living is present in the Rorschach record. In psychatric and alcohol problems we often find an inadequate psycho-sexual adjustment, and any tensions of this sort are clearly present in a Rorschach analysis.

For the alcohol patient, therapy in its broad sense –and it must always be considered in this sense–includes: relationship between patient and physician; placement (hospital, farm, office); psychotherapy; co-operation of relatives and friends, the importance of which cannot be overemphasized; long-range plans with follow-up; and the goal–stated at the outset–of total permanent abstinence for life.

If a man is an alcoholic, unable to handle liquor yet unable to leave it alone, so that it interferes with one or more of his important life-activities, the only possible "cure" for him is to learn on a daily basis and under guidance how to live with himself and others in a reasonably contented, efficient and productive way without using alcohol. He cannot learn to drink in a controlled manner, limiting himself to one or two cocktails or highballs, any more than a man who has asthma can limit himself to three sneezes a day. Obviously, to learn how to live without alcohol, to become re-educated, a patient must have or obtain insight concerning himself, his drives, deep or deeper underlying anxieties and fears, his personality liabilities and assets. Even more obviously, capably to guide an individual so that he does get a constructive self-understanding and control we must know more about the patient than his name and the fact that he drinks too much.

Experience and intuition are not always infallible. Moreover, with today's accelerated pressures and demands, there are usually not enough margins of time to allow adequate sifting and weighing of facts quickly to reach a working knowledge of the patient. It is here, supplementing formal psychiatric procedure, and as a time-saver and short-cut that the "inkblot analysis" can help like a third hand.

When properly administered and intepreted, it reveals among other findings what type of psychiatric personality makeup we deal with: neurotic, with or without overly aggressive drives; predominantly psy-

chopathic (the so-called "bad egg"); schizoid, or oddly mentating; manic-depressive without evident psychosis, and so on.

A young married professional man was hospitalized for acute alcoholism and drug addiction. He was reported as having made a suicidal attempt (overdose of drugs) a month before admission. His past history showed marked emotional instability, and psychopathic traits, including theft and professional dishonesty. After the toxic condition cleared up, he began demanding his rights and was generally and specifically a trouble-maker, stirring up the other patient, annoying the nursing staff and "subversively" hostile to the physicians.

An outside consultation was arranged to see if a psychiatrist not associated with the hospital might be able to establish interpersonal contact with him. His attitude however remained the same. Kindness was tried, and failed. Sternness was tried, and failed. Appeals to his reason and to his pride were likewise unavailing. The feeling was that we dealt with a psychopath who had some neurotic traits. His wife was told that medically he should have long-term hospital stay and disciplining; but he prevailed upon her to take him home. When last heard from he had run off with another woman.

His Rorschach showed him to have marked neurotic traits, and psychopathic drives superimposed on an essentially schizoid (oddly mentating and asocial personality that had never been able to adjust to life, people, or reality in any sense. Strong explosive elements in his emotional makeup rendered him helpless and inaccessible to reason. Due to the basic feeling of "being alone in the world" and the schizoid structure, he was a victim of a severe psychiatric maladjustment and personality illness for which he had never been treated and the subjective symptoms of which, mental and behavioral, he attempted to allay by alcohol and drugs.

It was anticipated that he would continue to get into worse and worse difficulties until his wife recognized that he was mentally ill. A strong possibility of suicide was also present in his Rorschach record.

In this instance, use of a Rorschach indicated the presence of an underlying psychiatric illness not yet evident in behavior other than drinking. Because this patient did drink and used drugs, his unethical acts and dishonesty appeared to his family to be wilful or irresponsible, and—in part—direct results of his drinking and "dissipation." Actually, as the Rorschach showed, in addition to other factors and complications, he was severely mentally ill.

As mentioned before, a Rorschach analysis aids in a differential diagnosis of types of alcoholics. In general we have the following six groups: psychotic, with or without deterioration; neurotic; feebleminded; constitutionally inadequated endowed—the bad egg type; those who drink to narcotize physical or psychic pain—maladjustments, neuroses, sexual difficulties and friction between the neurotic personality and the world; and those who have developed from social into abnormal antisocial drinkers as a result of habit plus time plus body changes and ordinary strains of daily life. Often a patient is a borderline case and in order properly and adequately to treat him, we must know which border he is nearest to—psychotic (without manifest symptoms), organic, situational and so on. In all of these cases a Rorschach provides objective and supplementary—or corroborative—data.

Although for psychiatric purposes of diagnosis and therapy we classify the alcohol patient in these groups, there is, of course, no one definite alcohol personalty type and therefore no one definite alcohol Rorschach "x-ray." We have found, however, that certain signs and combinations often appear in the Rorschach of the "bad egg" alcoholic (the psychopath); in that of the "situational" alcoholic; and in those of the maladjusted or the neurotic alcoholic. Other types such as the psychotic schizophrenic, for example, present clear cut clinical picture and the usual Rorschach signs for that behavior picture.

As we have said, the individual who uses alcohol to excess does so for many psychiatric "reasons" which are usually deeply submerged and about which he is usually unaware in any helpful way. His use of the inkblot pictures, according to Rorschach ratios and other criteria, reveals these or certain characteristics, traits and trends to help us identify that group in which, again for psychiatric purposes, we classify him.

It might be well to comment here on the fact that an individual looking at the Rorschach pictures has no way of knowng how his interpretations will reveal his true self. What he sees or says has secondary significance. We are more concerned with *where* he sees the things he does see and *what* about the picture makes it look like a flying horse, or dancing clown. In accordance with the standards of the Rorschach criteria, we "break down" the "where" and the "what" into the final interpretation or analysis.

Thus an individual handles the fundamental life-situations incorporated in the plates (that is, the easy, the difficult, the non-stimulating, the threatening and so on) in the same way as he would handle those situations in daily life. It is what he uses and how he uses it that counts.

Interesting is the fact that experiments have been made with different groups who were told that a certain type of response was a sign of genius. Even with this knowledge as a spur, those who could not actually see that particular picture-type were unable to give the response with adequate substantiation.

In every Rorschach analysis one informs the individual that there are no right or wrong answers and he is requested only to tell what the inkblots look like or might be. Later, he is asked to show us where these "pictures" are and to tell what about the inkblot made it resemble the flying horse or the dancing clown. Accuracy of explanations determines in part the scoring; and inaccuracy, or inability, to show these pictures to us may—when checked with other signs—indicate, to name a few, organic brain damage, feeblemindedness, psychosis, or malingering.

Complete freedom is given the individual and, without any help or suggestion, using the material in his own way, he interprets the meaningless, projecting on it his own inner thinking, feeling, acting and reacting habitual behavior. Put in another way, one could say that as he looks at this blot of ink he takes or uses only that which has meaning for him. In the same way in daily life, some people laugh and others become very depressed by the same situation: – or "a primrose by the river's brim a primrose only is to him."

There are many steps in a Rorschach evaluation of what an individual has seen in these ten inkblot pictures. Except in rare instances, no one finding is alone conclusive. Because of this system of check and counter check this indirect method of analyzing a personality structure (a so-caled projective technique) is remarkably accurate and reliable. Although there may of course be occasional disagreements between experts, as in any field, anyone with requisite training should be able to "read" a Rorschach record which has been properly taken and reach the same or an equivalent interpretive conclusion.

With these foregoing facts in mind, we have found that certain definite signs appear in the Rorschach record of certain alcohol "types." Florence Halpern, psychologist at Bellevue Hospital, New York City, who has worked intensively with the Rorschach, has suggested a constellation of signs for the typical aggressive alcoholic of the kind that people say "no one can do anything with." We have also a group of signs for the "neurotic" alcoholic, including those who drink to escape from general or specific life-situations or from feelings of inadequacy and so on.

In many instances we have found that this latter type of drinker has difficulty in handling new and threatening situations; that there is often a strong mother attachment and lack of true maturity; that there is a tendency to introspective preoccupations without purpose; and that the makeup is hyper-sensitive and fretted with emotional difficulties and egocentricity. Clinically we expect to find a variety of personality motivations including self-destructive tendencies, psychosexual tensions and so on. In the individual Rorschach record, many of these are present so that, again, the analysis serves as supplementary or corroborative evidence.

A brief fragment-example of this type of alcoholic personality is of two male patients who were given a Rorschach after they had been in a hospital two weeks. The findings enabled us quickly to sort out some of the motivations and, in part at least, to discriminate between overt situational stresses and inner tensions, as well as between the neurotic and psychopath-like features objectively presented by the reported behavior.

Based on the Rorschach findings, without other objective or subjective data, the younger man was interviewed and the following material elicited. For three years prior to admisson he had suffered from, and been treated for, severe chronic colitis. Of husky build, and with some aggressive traits and mannerisms, he nevertheless felt himself inadequate and at times very nervous, characterized by petty temperish irritable spells and a nagging insistency about details. The other patient, about whom we had more background material independently of the Rorschach, also stated that he was subject to moodiness and "needless worry," that he had "butterflies in his stomach for no good reason," usually associated with prolonged dull headaches. Both said that they drank to obtain a feeling of self-confidence, to relax and to "cheer up."

Aside from this helpful evidence of basic personality structure, therapeutic procedure was clarified. That is, knowing these patients were over-aware of petty details, we were prepared for and so able to avoid some of the tedious discussions of the non-essential which often "block" therapeutic continuty from progressing in a relatively straight line. With certain patients, this brand of obsessiveness sometimes does not show itself in its true colors or full strength for many weeks; and the therapist may then find a whole forest of thorny misunderstandings and pedantic assertions that must be hacked through to a clearing and fresh start. Thus, small though this sign may appear to be, it is of great importance in treatment and treatment-approach. When present in any

patient, the therapist who knows of its presence is given a warning light to proceed with caution and non-discursive comments—or be willing to take the consequences.

When little or no objective data is available, a Rorschach analysis can be of great help in making the initial diagnosis and in outlining plans for treatment. We have another set of Rorschach records on file—one of a man, the other of a woman.

Both came for help unaccompanied. Both had a severe admitted drinking problem, and a history pointing to a psychopathic makeup—many jobs, inability to learn from past mistakes and so on. Both were married. Cooperation from the mates is easily summarized: while the patients were under our care, we heard nothing from the wife. From the husband we received two telephone calls.

Both patients were given a Rorschach at the initial interview. In each case, the record was one of marked emotional instability, and marked, propulsive violent emotional forces that threatened to overpower inadequate thought controls and leave the individuals wide open to primitive, emotional "explosions."

In addition—and with the alcohol patient this is a very important factor – both had an exaggerated sense of personal importance and "prestige." Given: personality immaturity, and emotional instability, this "prestige" factor is frequently the weight that tips the scale. Skillfully utilized in therapy, one *can* work on this sense of pride and prestige, and so get the "ego ideal" working in behalf of the total personality and on a constructive basis. Many people drink to escape from feelings of inadequacy that result from an in-adequately oriented and purposively directed prestige drive. But this element is dynamite. We all know, from practical experience, that false pride drives many a man and woman to self-destructive activities. With the alcohol patient, especially, there comes a time when this sense of prestige turns outward, constructively, or inward, with fatal destructive finality.

For this man and woman, therapy and placement were clearly indicated by their Rorschach analyses.

Essential was a long period of time in a protective environment, with discipline, retraining and direction of their drives and behavior patterns, and practical commonsense adjustment to reality, to break up their habit of "fantasy" and compensatory daydreams.

Both, in spite of superficial social adjustment—the ability to carry on light conversation and banter and to say "please"—were very poorly adjusted in their social relationships, with a tendency to feel misunder-

stood. Moreover, in both cases, neither mate was interested enough to appear in person or help out in any way. These foundlings just arrived on our doorstoop.

One patient, after a brief hospital stay, had so great a "prestige drive" that he minimized the seriousness of his drinking problm and besieged his friends to get him an executive Park-Avenue-type job. Medically and psychiatrically he was in no condition to leave, and although the financial worry would have been eliminated by placing him on a work-patient basis, he would listen to no suggestions along this line.

The other patient soon wearied of the mild restrictions and monotony of daily "hospital" life. Both patients were so deeply emotionally led—or driven—that with no one else to back us up, we could not get a foothold on them, and they could not get a hold on themselves. In such an impasse, one looks for the worst to happen. It did. Within the year, both patients killed themselves.

From the point of view of the Rorschach as an aid in determining therapy, including placement, these two records are highly significant.

Outwardly, both patients when first interviewed were aggressive, self-assured in behavior, not visibly depressed, nor had they disturbing symptoms save a vague general restlessness. The possibility of suicide was, however, indicated by their Rorschach analyses, in the emotional instability, emotional force and push, the lack of control, the wide mood-swings, and the *basic* depression in the personality, with poor adjustment to reality and an exaggerated sense of personal prestige. In cases such as this, long-term therapy in a protective environment is the only possible safe plan.

Important to know in the treatment of a patient with an alcohol problem is whether he has progressed or regressed during therapy. If the latter, presence of a severe psychiatric illness, without any as yet manifest symptoms, must be ruled out.

A re-administered Rorschach is of help in both instances. It is further helpful in making decisions such as transferring a patient from mental hospital to a less protective environment, discharging him to office therapy, or recommending him for a job.

We had a patient—a 32 year old, married college graduate – who drank on a spree basis. His first Rorschach showed him to be depressed, aggressive, with an indifferent attitude, capable of producing more than he actually did produce, and subject to irritable spells. A tendency to shirk adult responsibilities was present, and a poor social adjustment with sulky rejection of social situations.

Three months later while he was still under treatment the Rorchach was re-administered. It revealed a more stable prevailing mood, a shift in aggressiveness to a better practical adjustment, and greater willingness commensurate with his known and proven capacity to assume adult responsibilities.

Among other factors, we needed to know what changes in attitudes and emotional patterns had resulted, for this man was scheduled to work with a large group of people in a supervisory and executive capacity. The findings of his second Rorschach indicated that good progress has been made and that his ability to get along with people had vastly improved on a mature level. In spite of some unfavorable external factors, subsequent actual success of this patient in his new work showed that the Rorschach analysis had accurately recorded fundamental changes in the personality structure as a result of therapy.

Alcoholics are individuals who have an alcohol problem: that is, their drinking is seriously interfering with one or more of their important life-activities. They need psychiatric help and guidance for they are emotionally ill or severely maladjusted.

The alcohol patient is an individual, with intelligence, emotions, memories, ambitions and "complexes" of various types and intensities. He must be treated *as* an individual. In attempting to understand him, and so help him to obtain the constructive self-understanding and control that he needs if he is to be successfully rehabilitated, a Rorschach analysis is of aid in the following ways:

(1) It serves as a differential diagnostic tool, helping one determine where best a patient will fit in (hospital, farm, or office) since a Rorschach indicates whether or not the brain has been damaged; the presence of any major mental illness; the type and level of intelligence; the depth and stability of emotions; the level of emotional maturity—willingness and/or ability to assume adult responsibilities; the presence of manic depressive or mood swings with suicidal risk possibility; and whether or not the individual has a tendency to be dishonest, consciously or unconsciously.

(2) It helps uncover basic mechanisms, specific disturbances, anxiety and/or conflict-producing situations, and adjustive techniques in handling these, and self in life (goals, drives, perseverence, etc.)

(3) It is a time saver in treatment itself, and in making therapeutic plans and safeguards.

(4) The Rorschach analysis can be re-administered, and serves as a way of checking up on progress, or regress not yet observable in behavior and thus "alerting" one to the need for other tests and change in therapy.

(5) Further useful functions of the Rorschach are: it is easy to give—and to take—at the most it rarely requires more than two hours to administer. Its results can be rather quickly evaluated, depending on skill, knowledge and experience. Its findings can be used to explain to relatives "why" an individual drinks and behaves as he does, not out of wilfulness, but due to inner conflictual pressures of which he, like they, may be completely unaware. With time at a premium, it is of distinct aid to the therapist working under pressure with many individuals, in understanding the basic, *individual* personality makeup, and of course, it can be referred to at any time, and the summary psychogram "taken in" at a glance, exactly as if it were a chest x-ray or other laboratory report.

In conclusion, we consider the Rorschach as probably the best objective diagnostic scientific method of indirect personality analysis and study, and for use in borderline or difficult cases, and as a new helpful approach in understanding the alcohol patient. It is a technique that will become increasingly useful and important in the field of medical psychology and in the curative and preventive field of alcohol hygiene.

Preventive measures include the *recognizing* of a so-called "predisposed-to-use-alcohol type," that is, a personality makeup which, due to various stresses and factors, endowed and environmental, may be anticipated "to break" under strains of life and to turn to alcohol as a crutch or escape. Early detection (which a Rorschach analysis helps make possible) of this type makeup, and prophylactic psychotherapy and other measures are certainly implicit and fundamental in the concept and practical functions of alcohol hygiene.

THE CHALLENGE AND SOLUTION OF JUVENILE DELINQUENCY

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NATURE OF THE PROBLEM

Juvenile delinquency may be defined as any violation of the social codes by a child below the age of 16, at which time an individual obtains adjudication for his violations in an adult court. Many of the juvenile offenses are mild in character and such events as truancy, desertion of home, and ungovernableness are inapplicable to adults. On the other hand, there are the more serious juvenile offenses of stealing, burglary, and robbery, and still others so volent in character, that in the adult they would be equivalent to felonious assault, manslaughter or murder. It recalls to mind the recent case of an angelic-looking boy of 12 who killed a four year old child by throwing bricks from his roof. The boy came from a broken home, had been undisciplined and unchecked in previous exploits of throwing marbles and stones at children from the roof, when his brazenness and usual disregard for others suddenly expanded to the throwing of bricks.

The approach here is singly from the view of cases treated at the Children's Courts of New York City. While it is recognized that there are many more offenders in the community than appear at Court, because of non-detection, non-apprehension, or treatment of certain offenders by the family or outside agencies, yet it is an undisputed fact that the worst juvenile offenders have their day in Court at one time or another. Habitual delinquents may commit many offenses before they are caught in one; nevertheless, it is almost axiomatic that a boy whose personality is deviated toward antisocial conduct is likely to pursue this course uninterruptedly in one offense or another until apprehended by the police. The exceptional instances, where a youth through curiosity, adventure, or impulse, commits one or more acts and then spontaneously reforms is of no concern to himself, the community, or this work.

The natural question thus arises, that if nearly all of the worst juvenile offenders at one time or another appear at Court, why are the necessary precautions and measures not exercised to insure complete deterrence? In other words, if the juvenile courts obtain custody of the most challenging problems in the community during early life, why is not a cure achieved, and why do these juveniles later appear repeatedly in adult criminal courts? To the untrained mind this would appear incontrovertible evidence of failure on the part of the juvenile court in its specific function of rehabilitating youngsters who come before it. On the surface, the indictment would seem inescapable, that since the Juvenile Court was established for the prime purpose of checking young delinquents from continuing into a career of crime, this Court is singly at fault in permitting a condition to exist where boys pass through its doors to become finished criminals.

While, to some extent, such criticism is excusable in the instance of a lay member of society, unacquainted with the deeper elements underlying the morbid socio-pathological mechanisms that render certain fixed delinquent types incurable, it is nevertheless deplorable when accusation is levelled at the Children's Court by outstanding representatives of the adult courts, in blind condemnation equivalent to: "If your Court, which sees many of our worst criminals when they are young, pliable and curable, would perform its duty properly, we would not have to be confronted with the hopeless task of attempting to cure confirmed adult vicious characters."

It so happens that whenever a peak is reached in crime and delinquency the attention of the community is suddenly and sharply withdrawn from its laissez-faire attitude of "Let the other fellow do it. He is being paid for it." On such occasions the public mind becomes strongly aroused, and in its stupid excitement looks for a scapegoat, orders an investigation which rarely achieves anything, or provides some temporary palliatives, such as the appointment of one or more judges, occasionally a probation officer, or even a psychiatrist; the issue is momentarily allayed by a temporary surge of enthusiasm, publicity and effort, and the main essentials in the faulty social structure are permitted to continue just as before.

We are unfortunately passing through a crisis in delinquency, at present, which in a measure is contributed to, but not caused, by factors deriving from the war effort. Admittedly homes are broken, with father, mother, or both parents working out of the home, and providing little or no supervision for children during the crucial hours of the day. Such

parents are tired at night and have little energy or interest to cope with family needs and the guidance of children. Many of them are tempted by newly-found large earnings to indulge personal satisfactions and pleasures denied them during the lean years. The adolescents are similarly excited by easy earnings, at part or full time jobs, and normal interests and standards become disrupted. There is a greater urge for adventure, new experiences, and forbidden pleasures, in consequence of which, school and home lose their former significance, and truancy and desertion become frequent features. Too much leisure, money, and unsupervised time is unhealthy for young people, and they come into difficulties through imitation, temptation and evil influence. The precocious 13 year old girl now yearns to ape her 16 year old sister or friend, pins up her hair, borrows high heels and cosmetics, and is proud that she is accepted as a grown-up by sailors, or evil characters, in trips to hotels, saloons and dances. The war situation adds such, and similar, instances of delinquency to the total of the community, and the court, but does not materially alter the structural dynamics of delinquency. One might rather state that under war and so-called normal conditions, *some roughly ten percent of the boys appearing at Court are of the vicious, hardened and aggressive habitual delinquent type*, who espouse antisocial behavior as a career and the gang as a medium of protection, comfort, and training for effective operation. This potentially dangerous nucleus among the young people capitalizes on any occasion, circumstance, or situation that will further its aim and gain, and is ever on the alert to recruit new prospects, disciples and tools to conduct its drive against the old enemy—society.

War conditions afford a more fruitful field for operation of these unlawful elements, in that otherwise good children now become fertile material for delinquent schooling, as the result of absence of parental supervision and the excitement of the time, which serves to unloosen greater tendencies toward taking risks and satisfying impulses. The aggressive delinquent finds no difficulty in impressing such gullible boys with accounts and display of ill-gotten gains, in intimidating the weak ones, or in entangling the unsuspecting ones by threats of exposure for complicity in minor affairs. The pattern of the entrenched habitual delinquent, through reputation, imitation, or direct influence, largely forms the foundation for the war-time increase in the frequency of delinquency, but the novices do not materially alter the basic, morbid condition and problem of delinquency. If the old adage that "a rotten apple will spoil a barrelful" is important enough for the farmer to take appropri-

ate measures to protect his crop, it is *unthinkable* that city folk can afford to be so inanely indifferent as to permit one gangster to ruin a whole street of children. Yet such is the tragic truth.

THE SCOPE OF THE PROBLEM

This ten percent among the juvenile delinquents constitute the real challenge to the community and its institutions. While the percentage seems small, yet when the total effect and impact of their number, activities and later course as professional criminals are considered, the damage to society is tremendous. If one recognizes that the Children's Courts of New York City handle annually some 5,000 delinquent boys,* 500 vicious psychopaths recruited every year is a matter of serious concern in terms of property and physical injury to society, the demoralization of thousands of good boys, their treatment needs, and management. These boys usually range between 14 and 16 years of age, are often powerfully built in body, fearless, Godless, and schooled in all the crafts of offensive behavior. They have no ties to their families and no regard for the welfare, property rights, or feelings of others. Many of them already display a paranoidal-psychopathic attitude toward society. The school is only a place to violate, obstruct, or ravage, when they do attend, and they usually do not. Many of them are ugly and sinister. They delight in corrupting the morals and conduct of better type boys to utilize as followers in their escapades, and to help inflate their ego as leaders. Defenseless, unsupervised boys readily succumb to their influence, teachings and leadership.**

These hardened delinquents are skillful, shrewd and cunning in their chosen craft, despite the fact that they usually rate low on I. Q. forms, with many bordering on the feeble-minded level and some even committed to feeble-minded institutions, for want of better evaluation or facilities. Let there be, however, no mistake about the issue. The

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* *Annual Reports of Domestic Relations Court,* City of New York, 1936, p. 51; 1937, p. 45; 1938, p. 67; 1940, p. 86.

** "Boys are not infrequently compelled to face such situations against great odds, either because shame and pride prevent them from turning to parents and guardians for assistance, or because some parents are known to tell their children, if they complain of difficulties with 'tough' boys, to 'fight their own battles.' Thus many children who intrinsically detest the ideologies and behavior of delinquent types, nevertheless eventually, through pressure, are forced to accept these conditions for protection and security. They become warped in personality, so that they soon become indistinguishable from the others, and in turn serve to drag still others down to this level." Doshay, L. J., *The Boy Sex Offender and His Later Career,* N. Y., Grune and Stratton, 1943, pp. 40-41.

dangerous delinquent is not feeble-minded, and the true feeble-minded boy is no menace or problem to society, albeit, he might commit some spontaneously-generated violent offense. The true feeble-minded type is not shrewd enough to plan, organize, or even follow the directions of the gang, nor could he skillfully evade questions or keep secrets, which are essential traits of the successful gangster; nor would he be trusted by his accomplices. The 70 to 80 I. Q. of the habitual delinquent is not a true measure of his native intelligence, but is the result of a withdrawal of his intelligence from school interests and academic acquisitions to street interests and delinquent acquisitions. It is, therefore, not surprising that, when such a boy is suddenly thrust on a battery of material, largely dependent on school routines, attitudes, and skills, he shows up to disadvantage, and psychologists ponder the fact that four years before his I. Q. was 98, and two years before 85. They also marvel that his reasoning and visual imagery are at the fourteen year level and yet his reading and arithmetic are only at the third grade level.

The evil influence of the aggressive delinquent on other boys in the community is legend. He is restless, hyperactive, and driven by excitement and a madness to satisfy his personal pleasures and hate of society, through any type of venture. He might even engage in ball playing with other boys and appear so innocent for the moment, but all the while his mind is scheming as to where to go next and where to strike next. Suddenly an idea crystallizes and he bellows, "come on fellows, let's go and have some real fun." This boy had reminded himself of an empty apartment house that would make an easy place from which to reach and rob adjoining occupied homes. They follow him to the subway, and on the way they steal money from newsstands, rifle the pockets of a smaller boy, are chased, and rush to the subway. One is caught, but the leader is crafty and most often gets away. The boy who is caught rarely knows the name and address of the leader, the latter always shrewd enough to operate in distant areas and to allow himself to be known only as "Bill," "Red," or "Nick." They sneak into the subway, rummage through the cars, annoy passengers, rifle the pockets of a drunken man, get out in a downtown section, loiter about the counters of a five and ten cent store, borrow a few articles, are chased, and some are apprehended and admonished by the manager, who sometimes does not relish the inconvenience of turning them over to the police and having to appear in court. Off they roam to the roof of the abandoned house, climb down the fire escape of an adjoining roof to an apartment, already established as safe, by the repeated ringing of the door bell. They

steal whatever they can carry away. Radios are hidden on an adjoining roof for a later occasion. The cash is divided to the advantage of the leader and the complete satisfaction of the others, and off they march to enjoy the proceeds in movies, ice cream and candy. They are late and the leader suggests that they stay out for the night: "It's a lot of fun, why don't you try it?" he slyly volunteers. So they follow his bidding, and tomorrow starts another day. Sometimes the leader employs persuasion, sometimes intimidation, sometimes appeal and strategy or bribery, but through one means or another, he always manages to maintain his sway over several followers. A still shrewder one builds a wider domain, and allies himself with a neighboring or several neighboring gangs. Thus the poison is spread.

The automatic or habitual delinquent is a surly, sullen and reticent character. He has been wisened and well educated by the gang as to his rights, risks, and safeguards,* so that he faces court with little concern as to consequences and in turn the court makes little impression upon him. He has been prepared to face the situation with arrogance, callousness, slyness, or indifference, and is basically resistive to guidance, entreaties, or admonitions. He responds to advice with insincerity and smugness. He passes, so-to-speak, through the court, but the court does not pass through him.

The Judge looks at the hardened 15 year old delinquent before him. In terms of years he is only a child, but there is every evidence that he is definitely embarked on a career of crime, and yet what to do about it. Reasoning with a boy of this type is futile. He regards kindness as a sign of social weakness, and harshness as unfair, to which he is known to react with greater hate, aggressiveness and sadism. To return him to the community and the rotten soil from which he stems, after repeated offenses, no insight, and no prospects, is palpably useless. Yet, to commit

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* "The present study does not advance the thesis that the gang is a "cause" of crime. It would be more accurate to say that the gang is an important contributing factor, facilitating the commission of crime and greatly extending its spread and range . . . The boy in the gang learns the technique of crime by observing it in older boys . . . Exact information as to the technique of crime is imparted in the gang. Experience in a gang of the predatory type usually develops in the boy an attitude of indifference to law and order—one of the basic traits of the finished gangster . . . The gang boy very early acquires the independence which is characteristic of the finished gangster—learns to sleep away from home and live on his own (predatory resources) . . . The boy usually acquires in the gang an attitude of fatalism, a willingness to take a chance—a philosophy of life which fits him well for a career of crime." Thrasher, F. M., *The Gang*, Chicago, University of Chicago Press, 1936, pp. 381-392.

this type to a juvenile institution is hardly the solution under present conditions of overcrowding, lack of adequate personnel, hampering legal and social limitations, and absence of proper planning.

The Harlem situation is a particularly fruitful source for the recruiting of new delinquent material and there are many such poisonous areas of delinquency and criminality in New York City. It is not through mere chance or fate that criminals are continually and regularly grown in these areas, unchallenged by society, which, like an ostrich, seems to take no visible cognizance of the abominable situation. That certain environments continually breed crime is not speculative, but supported by careful and objective studies.* Yet society makes no provision to remedy the condition, but continues to employ pallitative measures which must inevitably fail, since they do not reach into the roots of the problem. When tonsils are diseased, people do not toy with palliative treatment, but have them removed to conserve the rest of the body. Strangely enough, however, the community fails to take any measures to rid itself of the poisonous criminal areas and elements that threaten its existence, but is satisfied to continue with antiquated placebos and compromises.

Now, the all-important question arises, who in particular is responsible for the continuance of such deplorable conditions? Obviously they are not desirable. That they continue is painfully evident from city maps of crime and delinquency areas, and from the yearly statistics of courts, correctional institutions, and prisons. Where then does the blame rest?

Is it the Juvenile Court? If so, let's examine its intrinsic structure, and the function assigned to it. Could it be the Judge? But, he is limited by laws either to return the delinquent to the community, or commit him to an institution. It is certainly not within the province of the Judge, nor could he possibly have the necessary time to regulate and supervise the program, treatment, or length of stay required for each boy at the institution. If the delinquent is returned to the community, he comes under supervision of the probation department.

Is the probation officer, then, at fault? Again, the probation officer can do no more in his limited time and burdensome program than to interview and advise the boy at *long intervals,* act when possible on complaints from parents, school or neighbors, and return him to the court in

* Shaw, C. R., etcetera, *Delinquency Areas,* Chicago, University of Chicago Press, 1929.

the event of new violations. If the boy is under pressure of a neighborhood gang, if he is under secret and evil influence of adult degenerates and criminals, if he visits shady places, if he is employed at cheap labor to the exclusion of school, if he sells stolen items to passersby or housewives, if he maintains late hours with the tacit agreement of uncooperative parents, who may be so antisocial as even to accept his stolen goods into the house, has the probation officer adequate time to exercise close check upon the boy, or to offer him the necessary protection? Does he have the time or means to bring the adults to quick justice? Hardly, since all these people would lie too readily before the Bench and satisfactory results are not too promising under present conditions. If the boy is returned to the Juvenile Court – what now? An institution? Does an institution cure these boys? What deterrent or curative values can an overcrowded, understaffed juvenile institution hold for a calloused boy, whose attitude is set on defiance, resistance or escape at the earliest moment, or accepts his placement only in the light of punishment to be gotten over with, until he can return and avenge himself on the community.

One might volunteer that such a boy should be adequately prepared by the court psychiatrist toward the proper appraisal and acceptance of institutional placement, as rehabilitation, and not punishment. Unfortunately, such pollyanna reasoning is impossible with the hardened type of delinquent. The time to cure these boys is before the morbid pattern is formed and not after the personality is warped, distorted, paranoidal, unreasonable and fixed in the antisocial direction. In prevention, and only in prevention, rests the cure for delinquency and not in treatment after the delinquent cofiguration is fully developed.*

* "There are less advantages in the home (of the delinquent boy), less supervision, fewer home ties, more street life, and much stronger conditioning by gang types. In time, the boy is led to ever increasing breaks from family, church, and school controls, serving to bring him into strange relief with accepted standards and requirements. This in turn leads to further disorganization of personality, as reflected in fear, anxiety, a distrust of society and its institutions, restlessness, rebelliousness, and general nervous tension. There follow desertion of home, maladjustment at school, truancy, late hours, and participation in demoralizing recreational interests. More and more there is a need for and indulgence in all types of predatory and exciting experiences to meet increasing demands for escapades into pleasure, and more and more there is a growing acquisition of skills aimed at the defiance of law and order, and an identification with the ideologies and practices of antisocial elements. There is a progressive abandonment to selfish impulses, and greater participation in juvenile offenses, sexual and other. Juvenile court contacts, clinic guidance, shame, guilt, and family and social exposure have less and less meaning to such personality configuration and less deterring effect. Among the more strongly fixed of these social psychopaths, self-respect, as well as family and personal

This implies *vigorous prevention, such as here outlined, to gain results,* and not the establishment of an impotent committee, bureau, or department, which functions in name only.

It must be apparent that the juvenile court, as at present constituted, and delimited in scope and function, is neither to blame for the continuance of delinquency *nor could it alone, by any stretch of the imagination, remove the challenge of juvenile delinquency.* The adult court, with its archaic legal machinery and ineffective parole system, *is even more assuredly incapable of curing the criminal,* as the antisocial pattern becomes more firmly fixed with age. The responsibility for the juvenile gangster, and later professional criminal, rests squarely with the community. *The fact that organized crime has continued to flourish to this day is directly attributable to society's failure to implement proper plans and measures for effective prevention.* Society has never knowingly undertaken *an honest and constructive program aiming at the eradication of crime.* It seems to have been *fully agreeable* to merely keeping it in *check,* and has displayed manifest and momentary concern only on the occasions *when it reached out of bounds.*

While it is to be anticipated that the frequency of accidental, spontaneous, and situational adult offenses, as well as crimes of passion, will be lessened by the indirect effect of the program to be outlined, *it should be understood that the immediate issue is the elimination of professional crime, racketeering and gangsterism* as a challenge to the security of our commnuity, just as organized gangsterism, motivated and unbridled, in Germany, began to assume proportions challenging the security of the entire world. In the same sense, *offenses among females* are not given serious consideration here, because they basically constitute little challenge to the community The sins of women chiefly consist of prostitution and allied offenses, or of isolated crimes of passion, except in instances when they are under the directing sphere of male criminal elements, when they may assume momentarily graver proportions.

Note continued from previous page.
identity, are entirely lost. They become dominated only by hate, desire for self-aggrandizement, and a drive for exciting experiences. There is a loss of hope for the future, colored by uncertainty, tension, and impatience to satisfy immediate ends. There is no regard for the law of God or man; further contacts with adult courts and penal institutions serve only to inflame the paranoid and antisocial phases of the personality, with accentuated hostility and viciousness toward the old enemy, organized society, and the onslaught continues more or less unabated, until death. (Case H. G., p. 94)." Doshay, L. J., *The Boy Sex Offender and His Later Career,* N. Y., Grune & Stratton, 1943, p. 158.

THE SOLUTION

Society can, and must, rid itself of organized crime and delinquency, but this will only be achieved through radical and heroic measures. It will not be achieved through wishful-thinking, evasion, or hushing of the situation to avoid arousing the people, or neighboring communities. It will surely not be accomplished by the feeble, half-way enforcement measures, at present employed.

It needs, furthermore, be emphasized that as long as *professional crime is permitted to flourish, just so long will organized and habitual delinquency continue to grow*, even though the adult courts may point the finger of condemnation at the juvenile courts, in their fancied conclusion, that if it were not for the juvenile delinquent there would be no problem of the adult criminal. Here one reaches the old enigma of which came first, the hen or the egg, but from the view of attack on the total problem of crime, the question becomes purely academic. While in the initial stages it is conceivable that untrained, deprived, abused and hostile children could readily have acquired strongly fixed antisocial patterns, which carried them into a life of crime, yet with time, these criminals in turn served to establish character types by reputation and rumor for other boys, not so deprived, to emulate and follow. More important still was the direct influence of such elements on the younger generation about them. Thereby the vicious cycle developed and nurtured itself, the older characters setting the ground work, plan, and direction for boys to follow, and these in turn, becoming older criminal prototypes, helped to enlist and mould ever increasing new recruits into the expanding army of crime.

It is recognized that in isolated situations and abnormal periods, such as the prohibition era, the temptation of lucrative gains could have induced idle and dissatisfied adults to embark suddenly on the adventure and profits of unlawful endeavor. These men, however, never possessed the fundamental fiber or morbid personality configuration to operate successfully and continually as a challenge to the community, unless fortified by, or allied with, habitual criminals, just as in the sporadic instances of enterprising alliances between cheap politicians, or crooked labor unions, and criminals

With crime coming of age and fully developed as a well established parasitic disease, however, the problem of concern is no longer that originally the spores were permitted fertile ground for hatching and development, but that now the parasites are so successfully entrenched in

the social structure that they breed thousands upon thousands of new spores yearly and provide excellent ground for them to develop and cultivate into mature types. Hence it is obvious that the primary challenge at present is the adult criminal, although it is not to be denied that the juvenile delinquent problem will concomitantly have to be taken firmly in hand. *Since the problem of the juvenile is so closely linked to that of the adult, and vice versa,* it is palpable, that in order to deal effectively with the issue of organized unlawfulness, the attack must be well integrated and coordinated to take in all fronts. It has come to such a sad pass, that in many sections of our city, it is next to impossible for decent boys to play or exist, without constant attack and pressure from marauding bands of young gangsters, and unless the issue is *soon taken in hand,* the community will be confronted with the *almost insurmountable task of coping with a vast and rapidly growing army* of delinquents and later criminal prospects. The gangsters have succeeded in spreading a *terror* behind the word "squealing," so that now they ply their trade without any fear of disclosure, or interference from those about them.

The greatest immediate need, in approaching a problem of such vast magnitude, is to enlist or appoint a "*cordinator of crime control.*" Such a man should be assigned the full responsibility of eradicating crime from the body structure of society, and he should be permitted a reasonable time in which to organize a suitable staff and plan of operation. He should be vested with sufficient authority and legal framework to make it possible for him to conduct his program, unhampered by petty politicians or narrow-visioned lawmakers. Obviously, a task of such dimensions and responsibility would require an individual of unusually firm personality, clear vision, integrity, sound background, and thorough understanding of the problem. He should be so set up as to command the respect and cooperation of the community, subordinates, and correctional agencies. If he happened to posses knowledge of the workings of psychiatry and the law, it would be to his advantage, but it is not necessary that he be a lawyer, a judge, or a psychiatrist. His staff of associates and assistants would similarly have to be individuals of sound character and full familiarity with the problem under consideration, since it would be their responsibility to sit in with boards and bureaus of the various independent agencies in the community to offer advice and guidance, under direction of their chief. The salary should be such as to invite and encourage men of the better sort to engage in the undertaking.

An intelligent coordinator with the help and information derived

from his immediate staff, would know precisely what measures to employ for the elimination of weak spots in the social corrective framework. Such items as crowding of prisons, improper segregation of inmates, mismanagement of funds and facilities, defects in the law, crime areas, gang elements, shady characters that foster and profit from crime, psychopathic and brutal parents who encourage crime, would all have to obtain vigorous attention and prosecution.

A centralized bureau of records should be at the disposal of the coordinator to provide full life data as to the possibilities and limitations of each professional offender. There should be established an adequate and well conducted system of prisoners for remedial treatment, or permanent confinement of criminals, with provisions for changing prospects and needs. A well trained staff of psychiatrists should be at the disposal of the coordinator, to advise on special indications and treatment requirements for individual offenders. A qualified legal staff should be available to offer guidance on changes and interpretations of the law, conformant with the aims and success of the program.

It should be the duty of the coordinator to assist and guide the courts in the handling of confirmed criminals in order to make certain that they are not adjudicated on the basis of an individual offense, but treated or incarcerated according to their needs, and *particularly and always in the interests of the safety and welfare of the community.* At the present time, *the criminal is overprotected by the law, at the sacrifice of defenseless citizens who are unfairly exposed to unjust suffering, hardships and danger.*

If we are to win this war against the criminal and his satellite juvenile delinquent, there must be a complete change in the principle and practice of the law. The professional criminal should no longer have to be proven guilty. *He must at all times be required to prove himself innocent and worthy of living among law-abiding people, without a trace of danger or detriment to them. The burden of proof* must squarely and fully be placed on the professional criminal, where it belongs, *in order that decent citizens may not have to walk in fear of him.* Good citizens must not be jeopardized for the sake of the impeccable legal protection of the forfeited rights of vicious criminals. Why the great misplaced sympathy and protection for the criminals, *who are incapable of profiting from it and regularly abuse it?* Why not remove the toughness, smugness, and daring from the armed criminals, *so that they cringe and walk in fear,* for a change, *instead of the decent, defenseless citizens.* The criminal has no rights, unless he can *unquestionably establish* that he

deserves a trial of the privilege to live among decent people, under the *closest scrutiny* of the parole officer, for at least five years, *and preferably ten.*

It is frequently difficult, and at times almost impossible, to establish evidence against these vicious characters, who possess under-world alliances, known to wreck cruel vengeance against any *informers. There should be no underworld of criminals, gangsters and racketeers.* Many good members of the community dare not testify against them for fear of reprisals and even death. Would any one have dared testify against the Capone or Touhy mob; would they have lived long enough to do so? It has come to a state where innocent victims of, and witnesses against, these entrenched criminals even have to be incarcerated, for their own safety. What a travesty of our stupid correctional system, that people who have been wronged, assaulted, stabbed and robbed, have to be placed under lock and key, to protect them against possible further injury, *should they remain in society*. Note the recent incident of one such man who was placed in "protective custody" and through worry, discouragement and fear committed suicide in his cell. This is exemplary justice, law enforcement, and social control. Dangerous criminals are permitted to remain in the community, and decent people must stay in jail for their safety. These isolated horrible instances are not in themselves as important, *as the unfortunate fact that there is a general popular acceptance of the power and danger of organized gangsters.* It serves to keep thousands of aggrieved citizens from revealing truthful evidence against them, *which of itself*, tends to encourage these elements to ply their evil trade with impunity. How many hundreds of mothers of children interviewed by me have told me of witnessing all types of horrible crimes in Harlem and the Bronx, but who feared for their lives and those of their children, to make any mention to the police or press charges.

Brevity of space does not permit a fuller presentation of the issue, but the following instance is offered. The other day, I had the case of a 16 year old girl whose family had been terrorized for an entire year by a neighbor, who was a dangerous criminal on parole. This man might obviously not have apeared so dangerous to his parole officer, but he was plenty dangerous to those among whom he moved, breathed, and spread his foul poison. He maintained an apartment with a woman whom he claimed to be his sister. He idled his time and preyed on society at whim, secure in his confidence that few would dare challenge his actions by reporting to his parole officer. His brazenness, no doubt, was encouraged, on the one hand, by the smug knowledge that to establish evidence

against him, people would have to face the *grave hazard* of identfying themselves, and on the other hand, by the cognizance that he could readily rationalize and explain away any unsupported complaints, in the absence of proof to the contrary.

This parolee made repeated advances to the girl's oldest sister. He sought to induce her to elope with him, but she managed to stall him off. The parents knew the situation, but feared the man and tried to gain his friendship, in order to stave off harm to their three girls, and in the meantime trusting to luck, that *perhaps* some other aggrieved citizen may report him. More recently he proposed to the 16 year old girl that she elope with him to Baltimore. In the hope of forestalling unknown greater danger, she secretly agreed to spend the night in the apartment of his so-called sister, and he foced her into sex relations. He made advances to several of her friends as well. Finally, 10 days ago, he induced the 17 year old sister to elope with him, through threats or means unknown, and the mother has not heard from the daughter since, and *now* in desperation, she has reported the matter to his parole officer. Must people be terrorized, assaulted, robbed, ruined, raped and killed, before these criminals are brought to justice, if, and when they are? Are decent citizens not entitled to public safety, security and protection? Why must they be sacrificed, in the interests of the *meticulous legal protection* of a vicious group of confirmed dangerous psychopaths.*

A drastic change is necessary, so that such characters will *at all times be under strictest scrutiny*. Parole officers are undoubtedly trying to do a good job, but under present conditions and system, their usefulness is limited, ineffective, and *no guaranty that the criminal behaves perfectly, or that society obtains the assured protection to which it is entitled.*

If a parolee assaults a man in the course of a holdup, is full justice done upon his acceptance of the indictment, wherein he receives a year, two, or five, in jail, on the plea of clever counsel, or the claim that he was under the influence of alcohol? Do the victim's subsequent residuals and later course obtain complete consideration? If the latter recovers from the injury and is back at work, the effects of the assault are assayed as

* "The items of outstanding significance among the adult general failures, as noted in the case histories, are the markedly poor backgrounds, the unstable and psychopathic personalities of these individuals, the almost inevitable criminal careers that follow, the ever increasing severity of the offenses, *the frequency of adult court appearances* without apparent deterring effect, *the great amount of fruitless labor and cost* expended by public and private agencies, in addition to the *assumption of great hazards by the community*—all in the interest of a vicious group of neurotic, psychopathic, and hopelessly maladjusted individuals." *Op. Cit.*, p. 122-3.

status operandi, for the purpose of trial and sentence. The court certainly does not follow the injured man's further career to evaluate the total lasting disabilities, nor his mental anguish throughout the years. The parolee goes off to prison, and the case of the injured man is closed and forgotten. Justice has been done, *but has it?* The criminal will be out again in a year or two, on good jail behavior, and now he is ready to assault a new victim. What about the former victim? No one cares to know what happened to him, once he survived the assault, and there was no danger of his dying. Perhaps a glimpse into the crippled life of a victim may help to elucidate the question posed here.

Mr. B. is now 35 years of age. At the age of 18, he received a head injury in the course of a robbery and assault. He spent two weeks in a hospital, during which time it was established that he sustained a linear fracture of the skull. He returned to work, and seemed fairly well recovered, except for throbbing headaches, for which he took heavy doses of aspirin. Little did he dream, or know, at the time, that his entire life would be distorted and ruined as the result of his injury. As time went on, he became more restless, irritable, and jumpy, his headaches worse, and his memory poor. At times he would forget his own name or what he did shortly before, but he managed to carry on within his limited needs. At 24, he suffered a severe head "cold," and his head pains became more aggravated. The slightest noise, even at a movie, would disturb him. He took to drink as an escape from his misery. He would retire to a quiet spot in a saloon, and drink in solitude, but never to excess. He harmed no one, and, although he knew that alcohol was detrimental, he seemed to feel the need for it. In 1942 he entered the service and, while in his tent, sustained a minor injury to the side of the head which had previously been damaged. He went into a coma lasting for a week, until unknown intravenous injections brought him to. With the history of the old injury, and the episode in camp, he was not considered suitable material for further military service, and was discharged from the army. He married shortly after. His nervousness and instability increased. He suffered transitory blackouts. Any commotion or provocation would produce head pains and confusion of such intensity, that in his own words he described himself as "actually feeling insane at the time." He came into severe conflict with his wife, because of his nervousness and temper outbursts, during which he would abuse and assault her. Sometimes he would cry uncontrollaby and apologize, only to repeat the same conduct soon after. His wife admits that he is by nature a good man, but she protests that she cannot continue living with him,

because of his intolerable and unpredictable behavior and frequent acts of violence during one of which he attempted to choke her. More recently, in a fit of despondency, he attempted suicide. He will, no doubt, eventually wind up his career in a State Hospital for the insane.

Could anyone, in soberness, believe that such a man's right to live and pursue his peaceful course in the comunity is properly protected, when society permits a psychopathic criminal on parole, or previously discharged from parole, to batter him into unconsciousness? Are his rights justly protected, after the injury, when the criminal is returned to prison for a short span, while he, as an innocent and defenseless victim, continues to suffer a lifetime of damnation, misery, and deterioration? Are the interests, furthermore, of such a victim's child adequately protected, with its permanent loss of affection and care from a father, who is likely to spend the rest of his life in a mental hospital, while the criminal is ever-ready to leave jail to assault many new defenseless victims? The ruined, wrecked, and destroyed lives of decent citizens, that follow in the wake of the onslaught of professional criminal elements, could fill a thousand volumes annually, if their intimate course through the years were fully recorded. Why must such a tragic state of affairs be permitted to continue, for the sake of a futile dream of reforming a mad pack of incurable psychopathic criminals?

These professional criminals do not change their stripes. Note the daily items in the press, of parole criminals, or ex-parole criminals, who commit assault, robbery, burglary, racketeering of various sorts, and murder. These are *in addition* to the countless crimes committed against society by these elements, *in which they are unapprehended, or unidentified*, because many people dread to make complaints against them. Thousands of these criminals continue in this course, as compared to the *few* who reform. It is merely a matter of waiting until they are caught in a new offense, in which someone is brave or desperate enough to offer proof against them, but, in the meantime, they more or less contiually prey on the community slyly, and ofttimes brazenly, unknown to, or unchecked by, the parole officer, or society, for the reasons stated above.

Why must society be plagued, and the younger generation demoralized, because of a *hopeless, wishful dream, that one out of a thousand gangsters may reform? The people deserve every benefit of doubt,* and not the professional criminals. These characters invariably continue in one unlawful career or another, depending upon the times, opportunities, and conditions They will turn to liquor, black-market, number, or policy racketeering, hijacking, burglary, arson, bank robberies, kid-

napping, labor union operation, politics, or after the war, perhaps, to the employment of the aeroplane, to further their ill-gotten gains and assaults on the community.

In the present emergency, these characters are excluded from the Armed Forces. They are not good enough to be killed off, *they are spared such sacrifice.* Only our best and finest boys are suitable for the "supreme sacrifice." These characters are not considered safe, nor a good moral influence, for the other boys in the servce, but they are good enough to remain in the community and prey on society, and some of them, temporarily, even hold, idle, or scheme at good paying jobs, because of the present *acute manpower shortage.* It should be remembered however, that their intrinsic morbid make-up will not permit them to alter materially, or lastingly.

A distinct change is obviously needed in the principle and practice of the law. The burden of proof must be shifted to make certain *that profession criminal types are excluded from society,* unless every provision is made to *insure that there is not an iota of chance for them to endanger or harm the community, or to demoralize the younger good elements in the community.* If they constitute a menace to the Army, with facilities for closer discipline and control, *they are at all times a far greater menace to society on, or off, parole.*

It should therefore be within the province of *such a coordinator* to strike at the roots of crime, not only in *the effective removal* from the community of dangerous elements, and *the eradication of conditions and neighborhoods that breed crime,* but also in the establishment of positive and constructive measures aiming toward the upbuilding of a stronger moral fiber in the youth of the country. Church attendance should be encouraged. Ample facilities for *supervised* athletics and sports in playgrounds, swimming pools, school yards, boys' clubs and gymnasiums should be provided for underprivileged sections of the city. There should be greater police protection in crowded areas. Closer supervision should be exercised over pool rooms, saloons, dance halls, night clubs, and the like, to insure adequate protection of adults, and particularly juveniles, against corruptive and demoralizing influences. There should be more vigorous prosecution of adults who pervert children. It should be the coordinator's duty to prepare the community to recognize the need for providing *social, economic,* and *health security* for large families, broken homes, and homes handicapped by the ill health of breadwinning members. It should be his duty to counteract intolerance, where ever it rears its ugly head. He should encourage educational programs

for parents on issues affecting health and guidance of children and, in particular should help stimulate a program aiming toward social acceptance of the need for *universal sex hygiene education of adolescents through the medium of the school.**

A capable coordinator should keep the public constantly informed as to needs and improvements required for the elimination of crime, so that he may obtain their whole-hearted cooperation, both in funds, and in the cleaning of their own house and conscience. Most people wish to be honest and lead decent, respectable lives, but there is a portion of the community that readily lapses in morals and standards, not through wilfulness or evil nature, but because of *a contagious feeling that everyone else does the same.* These people will be tempted to purchase a known, stolen article, merely because it is cheaper and on the surmised justification, that someone else assuredly will, if they don't. They will withhold crucial knowledge from the law that a neighbor stole, assaulted, or committed arson, forgery, or perjury, (and this may be done *even by a lawyer*). They will permit youngsters to become demoralized in their dance halls, night clubs, and saloons for monetary gain, on the rationalization that others do likewise. Such, and many other, infractions of the mores in otherwise law-abiding citizens would be rectified spontaneously by the knowledge that a stronger-functioning correctional machinery was in operation. In wilful violators, pressure would have to be employed by the enforcing agency.

It should be the duty of the coordinator to enlist the help of the public toward the end that sufficient and proper correctional institutions are established for the *safe removal of juvenile gangsters from society,* before they are afforded an opportunity to pervert, corrupt and recruit so many delinquent candidates, *as to tax all available community facilities out of usefulness.* The timely confinement of dangerous juveniles until they are definitely known to be safe to return to society *would put a fear into their proteges, who might otherwise follow in their footsteps. It would also serve to take the glamor* out of juvenile delinquency and help to remove the smugness and indifference with which the present hardened delinquent faces the Court, knowing the worst that confronts him is a year or two in an institution, which he could defy, escape from, or utilize for the nursing of a grudge against the people.

An adequate increase in the probationary personnel should be mandatory in order to insure that any juvenile delinquents returning to the

* Ibid, pp. 178-180.

community in their custody will strictly conform to social obligations, and that they neither fall under pressure of delinquent or criminal elements, nor willfully violate their promises and duties.

Suitable rehabilitation and youth centers with proper segregation, control, and direction by the different denominations, should be established for the special treatment of situational juvenile offenders, for unstable, impulsive and maladjusted adolescents, and for boys mis-led or handicapped by vicious home environments. An intensive effort must must be made to revamp the school program and grading to meet the practical needs of the large manually-minded population, the dull and slow children, who under unfair *criticism* and unfavorable comparisons by parents, neighbors and playmates, acquire feelings of futility and failure, which often induce escape mechanisms of truancy and desertion of home, and these, in turn, not infrequently lead to discouragement and abandonment into more serious delinquencies.

The plan suggested here is not a panacea, and it is anticipated that controversial issues, misunderstandings and difficulties are likely to be encountered, particularly at the outset. There may be resistance from entrenched interests among the various agencies, and perhaps even a certain distrust from well-intentioned elements in the community *against so much power being vested in one man.* Carefully hatched schemes to frustrate the plan may evolve from influental crooked elements. It is even possible that minor injustices may occur in exceptional instances. However, the problem is desperate and drastic measures are necessary, and since *this offers the only seemingly workable plan for the complete eradication of professional crime and juvenile gangsterism,* it will have to be resorted to by the community, sooner or later. If incidental errors are to be met with, they should rather be on the side of *protecting the community, than the confirmed criminal.* Some check on the coordinator would desirably be in order and might safely be entrusted to a responsible high government official, as a precaution against the unforeseen abuse of power.

These and other problems, however, should be successfully surmounted by a masterly coordinator and a well-organized program, aiming at the protection of society against *the onslaught of an expanding army of crime and its abuse and distortion of the law to its advantage, with the subtle help from professional criminal lawyers.* Lawyers must be citizens first, and as such should be obligated to aid the law with truthful disclosure of crimes committed against society, even when acting as defense counsel, and not to resort to the secret practice of con-

niving with the criminal to defraud justice and the law. How often lawyers have reminded me that they have nothing to do with 'justice,' 'truth' or 'ethics,' *that their only job was to protect the client.*

It must be admitted that *at present the law enforcement system is ineffective.* While there is superficial cooperation between the various departments and agencies, this cooperation amounts to little, since each agency, such as the police, the criminal court, juvenile court, prison, correctional institution, attendance bureau, and private agency, follows its own segmental course. The judge does his job as well as possible and then he is finished. The parole or probation officer does as well as is humanly possible under handicaps. The psychiatrist does his job, and so does the truant officer. The police officer does an excellent job, under legal obstructions. *Each one does his job, but no ones does the whole job of crime control.* It is true that cooperative meetings, conferences and luncheons between the various agencies do occur, but nothing is achieved, because each agency continues to regard the issue from its own limited field and jealously guards its special rights and privileges in its domain, and would hardly brook interference from another agency. The result is that no concerted attack is made on the problem, *and crime and delinquency continue to flourish.* Unless a coordinator is appointed with special powers to enforce vigorous integration of action by all the agencies *for the interests of the community*, little improvement is to be anticipated. The coordinator would, furthermore, direct the set-ups and activities of the agencies, so that their functions would interlock for maximum efficiency. He would also put into operation additional, and at present non-existent, functions and services, so that *the total effect of all the efforts will add up to success*, and not futility, lame excuses, and the useless blame of one agency by another, or unproductive investigations into causes and remedies for crime waves, which are regularly lost in shelves of paper, after a flash or two in the newspapers.

SADISM AND MASOCHISM IN HUMAN CONDUCT

PART II

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The Symbolic Meaning of Death to the Suicide

To a person interested in the problem of suicide, the most striking and impressive aspect of it is the death of the suicide. Thus, Durkheim[1] defines suicide as "a case of death resulting directly or indirectly from a positive or negative act on the part of the victim himself, executed with the knowledge that it would result in his own death." Other authors also stress the fact of the death of the suicide and make it the principal part of their definitions.

Two of the major factors, which lead a person to develop ideas of seeking his own death as a means of resolving his conflicts, are the loss of a vitally important libidinous object and aggression secondarily turned against the ego.

We will therefore proceed to study the symbolic, psychological value of death to an individual with suicidal tendencies. In other words, what does death mean to such an individual?

To raise this question at first appears to be a fruitless undertaking. It is natural to think that death holds only one meaning for the suicide, the escape from the conflicts which torment him by seeking refuge in nothingness.[2]

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(1) Durkheim: Le Suicide, p. 5.

(2) Thus in Tartufe, Act II, Scene III:

Marianne
De me donner la mort si l'on me violente
Dorine
Fort bien
C'est un recours ou je ne songois pas;
Vous n'avez qu'á mourir pour sortir d'embarass
Le reméde sans doute est merveilleux

Also, in Seneca:

Malum est in necessitate vivere, sed in necessitate vivere nulla necessitas est.

But this view, even though it sounds logical, is not correct. In most cases death not only signifies the finding of a refuge in oblivion for the victim but, on the contrary, it simultaneously furnishes the suicide with possibilities of life which he previously lacked. For example, let us see what motive for their suicide is given by a pair of frustrated lovers. They inform us that they desire to commit suicide in order to overcome all of the obstacles to their union in this life and to be able to achieve eternal happiness in the next life when they will never be separated from each other. Another example is the case of Werther who commits suicide in order to continue for all eternity the happy moment in which Carlotta gave him a kiss. And so, before dying, Werther exclaims, "At last you are mine! Yes, Carlotta, mine forever."(1) At the same time, just before the end of his life which he himself brought about, Werther does not really comprehend what death is, and says: "To die! The grave! These are words which I do not understand."(2)

To further illustrate how rarely death represents a complete negation of life to the suicide, we need only recall the description by Plutarch of a series of suicides which occurred in Mileto:(3)

> The youth of Mileto were afflicted by a sickness which was both strange and terrible at the same time . . . They were all impelled by an irresistible desire to kill themselves, preferably by hanging. Many did secretly hang themselves. Neither the entreaties or tears of their parents nor the advice of friends had any effect on them. Finally, it occured to a wise man to propose a law which would make it obligatory, when a girl had hung herself, to exhibit her nude body in the public square. The law was passed and as a result not only did the suicides stop but none of the young people even though of killing themselves anymore.

In other words, killing oneself did not mean their total death in the minds and thinking of the young people of Mileto, since they continued

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(1) Goethe: *Gesammelte Werke*. Ed Voegel. Berlin, p. 104, 1927.

(2) Op. cit., p. 103.

(3) Cited by Meng in *Gespräche mit einer Mutter über den Selbstmord*. "Beitschs. f psychoanal. Pädagoy", Volume III, p. 354, 1928-29.

to feel the affront and shame of being exhibited in the nude in a public place.[1]

In some analagous cases suicide signifies a gallant form of death to the victim. For example, one patient had fantasies about committing suicide in such a way that the upper half of his trunk would be exposed and people, viewing the corpse, would comment on what a fine and well-developed musculature he had. The brother of this patient actually committed suicide. On the day preceding his death he remarked that he would commit suicide by shooting himself through the heart. He added that this, in his estimation, was the most gallant form of death. He actually executed the suicidal act in this manner.

Then, there is the case of a widow who attempted to commit suicide with her ten-year-old child. After having made the decision to die together with her son, she made sure that he would be presentable and make a good appearance when they would find him dead. After the suicidal attempt was made, the boy died but the widow herself was saved. When she was brought before the judge, she made the following declaration: "I bought him a very becoming little white hat so that he would look very handsome at the time of death. While he was trying it on I placed a rosary, which I had bought for the event, around his neck. He looked at me and said: 'Mama, I will be very good; I assure you of that.' "[2]

The criminologist Gross observed that suicides never killed themselves by a shot in the eye even though the eye is the easiest target to hit accurately and in spite of the fact that such a shot would lead to death with the greatest certainty. But, the

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[1] In antiquity, the Athenian youth were probably not immune from suicidal tendencies because an epidemic of suicides occurred among them also. It is related in a certain legend that when Bacchus first introduced wine in that land, one of the first to try it was a person called Icarus or Icarius. This man, taking his dog with him, travelled to Attica. He presented some wine to a group of shepherds, one of whom became intoxicated. His companions, thinking that the stranger intended to poison them in order to take posession of their ewes, killed him. The dog who had accompanied Icarus, escaped and warned his daughter. She went in search of her father and when she learned what had happened and saw the body, she hung herself pronouncing a terrible curse. As a result a widespread epidemic of suicides among the feminine population broke out and did not subside until the oracle discovered the cause. Then the Athenians atoned for their crime and honoured the bodies of Icarus and his daughter. A great feast and celebration was instituted in their honor. Swings were constructed in trees and the participants rocked themselves in them, at the same time singing voluptuous songs. (Frazer: *The Golden Bough. The Dying God.*) (Note B. Swinging as a Magical Rite.)

[2] Cited by E. Ferri: *Homicide-Suicide,* translated by C. Pena. Reus, Madrid, 1934.

psychological significance of destroying his eye must be so shocking and painful to the suicide that this suicidal technique is practically never used.

The simultaneous existence in the same individual of suicidal ideas and of intense fear of possible accidental death further demonstrates the independence between the desire to die and that of committing suicide. Thus, one of our suicidal patients very frequently had suicidal ideas but he feared anything which might cause his death by fortuitous means. In spite of the fact that he was a good swimmer he was afraid to run the risk of swimming out too far from the bathing beach which he frequented, for fear – according to his own statement – of losing consciousness and drowning without anyone around to rescue him. Nevertheless, together with this fear of accidental drowning, the patient had ideas of suicide by throwing himself into the sea.(1)

The independence between the desire for death and that of committing suicide is further illustrated by the fact that, at times, attempts at suicide have been punished by the death penalty. The emperor Adrian decreed the death penalty for any subject attempting suicide. Only those were exempted from this penalty who attempted to kill themselves because of great grief, weariness of life, sickness or loss of honor.(2) Had the idea of death been the only motive of suicidal attempts on the part of the subjects, then the death penalty would have been considered more as an act of grace than a punishment.

Thus it is evident that death, as representing the negation of life, is not the only objective of the person who commits suicide. The same opinion is held by Kauders when he says: "In suicide we are unable to see more than an escape from life but in reality, *the motives of suicide in the minds of the victims are not death, nor the thought of death, but life itself.*"(3)

The idea of death cannot serve as the motivation for and the objective of suicide because we are unable to understand its real significance. Freud demonstrated that death has no meaning for the human unconscious mind. And before Freud, Goethe expressed the same throught in

(1) Paul Morand, in *Rond-point des Champs-Elyseés*, p. 94, describes a similar case: A Hungarian youth throws himself into the Danube and declines any kind of assistence. A policeman, aiming at him with his revolver, shouts to him: "If you do not leave the water I will shoot." "Revived" (in his own words) by this strange threat, the youth swims vigorously and gets to reach the shore.

(2) Citey by Plazeck: Selbstmordverdacht und – verhütung, p. 114.

(3) Kauders: *Der Todesgedanke in der Neurose und in der Psychose.* "Nervenartzt", Volume 6, 1934. (The italics are those of Kauders.)

the following words[1]: "Death is so strange a phenomenon that, in spite of all experience, it is considered as something impossible and is always represented as something incredible and unforeseen." Goethe has his character Werther say[2]: "The human race is so short-sighted that it does not comprehend either the beginning or the end of its existence."[3]

Aggression Towards the External World and the Recovery of the Libidinous Object in Suicide

We have, up to this point, examined only aggressiveness directed against the *ego* and voluntarily refrained from investigating the aggressiveness of the suicide against the environment. We have adopted this procedure in order to simplify and facilitate our study of the psychology of suicide. Also, this method of presentation has enabled us to take into account and cite the majority of writers who have concerned themselves above all with this aggressiveness towards the external world,

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(1) Cited by Kauders: *Der Todesgedarke*, etc., p. 290.

(2) Goethe: etc., p. 103.

(3) The writer Gerardo de Nerval, who died by committing suicide, wrote the following in the second part of his novel *Aurelia*:

"Death! What is death? Will it be nothing? No, by God! God himself cannot make death be nothing."

In order to illustrate how little the meaning of death is comprehended by the individual, let us cite the following verses from Baudelaire, which deal with the significance of death for different classes of people. We have italicized the phrases of most interest to us:

La Mort Des Pauvres

C'est la mort qui console, hélas! et qui fait vivre;
C'est le but de la vie, et c'est le seul espoir
.....
a travers la tempete, et la mege, et le givre,
C'est la darté vibrante á notre horizon noir;
C'est l' auberge fameuse inscrite sur le livre,
Où l'on pourra manger, te dormir, et s'asseoir.

Le Voyage

.....
O mort, vieux capitaine, il est temps, levons l'ancre!
.....
Nour voulous, tant ce feu nous brule le cerveau,
Plonger au fond du gouffre, Enfer on Ciel, qu' importe?
Au fond de l' Inconnu pour trouver du *nouveau!*

La Mort dest Artistes

.....
C'est que la Mort, planant comme un soleil nouveau,
Fera s'épanouir les fleurs de leur cerveau

To eat, to sleep, to rest, to encounter new experiences, and to reproduce are all important functions and Baudelaire considers death as the agent through which these can be realized.

forgetting almost completely and according to our judgment, mistakenly so, that the aggression is secondarily turned against the self. But let us now proceed to complete our description.

First, it must be pointed out that the suicide, by killing himself, seeks to free himself from the aggression of the environment in which he lives, and this represents a triumph to him since the environment or hostile world which oppresses him is cheated in its intentions.[1]

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[1] The following are cited as examples of this kind of suicidal mechanism:

In *Antony and Cleopatra*, by Shakespeare, fourth act, scene XVI, Antony, as he is committing suicide, exclaims:

> Silence! *It is not the greatness of Caesar which has destroyed Antony, but the greatness of Antony which triumphs over himself.*
>
> Cleopatra – It had to be so. *Nobody but Antony could vanquish Antony.* But what a misfortune that he should have succeeded!

In the same work, fifth act, scene II, seizing the asp which she applies to her bosom, exclaims at that moment:

> Give me my clothes; place my crown upon me; I feel within me a great eagerness for immortality. Now never again will the juice of the grapes of Egypt moisten these lips . . . I seem to hear Antony calling me. I see him raising himself to praise my noble deed; *I hear him mocking the fortune of Caesar . . . I am coming my beloved.* Now I prove, by my worthiness, my titles to this name! . . .

In *Julius Caesar*, by Shakespeare, fifth act, scene V:

> Brutus – Our enemies have beaten us and pushed us unto the edge of the abyss! *It is more honorable for us to fling ourselves in than to wait for them to throw us to the bottom.* Good Volumnus, you know that we two went to school together. Well then! in the name of our old friendship, I ask you to hold my sword firm while I throw myself on it!

In the Bible, *Book of the Judges*, Chapter IX:

53. And Abimalech came to the tower, and invading it, he reached the door of the tower in order to set fire to it.

53. But a woman let a piece of the wheel of a wind-mill fall on the head of Abimalech and it broke his skull.

54. And then he called to his shieldbearer and said to him: *Draw your sword and kill me, because it shall not be said of me that a woman slew me.* And his shieldbearer ran the sword through him and he died.

Also the suicide of Marta Hanan belongs in this category. This can be seen in the following news item taken from a periodical:

There can be no doubt that the famous imposter Marta Hanan committed suicide by taking an overdose of a sedative. Paragraphs which were underscored in some books which the victim had recently read, reveal that she intended to commit suicide and had prepared herself for death by appropriate readings. She was a cultured woman, and the books referred to were the *Essays of Montaigne*, the *Meditations of Marcus Aurelius*, and the *Maxims of Epictetus*.

In Montaigne's work the following paragraph appears underlined: "God denies us when he places us in such a state of being that to live is worse than to die." In Marcus Aurelius, Marta Hanan underlined these thoughts: "If men do not allow you liberty, then quit this life. As a man, you must think of nothing but suffering the least possible evil. There is too much smoke here; I am going. An instant more and you will be no more than a handfull of ashes, a skeleton, or still better, a name and not even that . . ."

GUSTAVE DORE: *The Divine Comedy*. "THE SUICIDES"

But, in addition, the suicide, by his death, attempts to influence the environment which encompasses him. He imagines that his suicide will cause a series of affective reactions among the persons who live together with him and this thought about the intensity and emotional height of these reactions to his suicide is one of the motives which impel him to commit suicide.

The suicidal individual desires to avenge himself on the aggressive environment which has brought about his desperate plight. He knows that by his death he will stop the environmental aggression against himself and that his demise will serve as a continual reproach to the external world.

Adler considers this desire for vengeance on the environment as the most important factor in the psychology of suicide. He states: "Thus, there originates in the unconscious mind, a state in which illness and even death are desired, partly in order to cause anguish to the individual's associates and partly to make them understand the value of the life which they had wronged. In my experience, this constellation is fundamental in actual suicides and suicidal attempts."(1)

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(1) Cited by Federn in the "Zeitschrift f. psychoanal. Pädayogik," Volume III, p. 337, 1928-29.

(2) The reader is referred to the following instances taken from literary works:

"And he suddenly found himself probing his inner mind with an egotistical and sentimental obstinancy. He would let himself be killed! Agila, in that moment, stretched out on the bed with his eyes closed and his hands clasped, found that death was a very mild occurrence. His ideas, taking on the fantastic logic of nightmares, showed him *the beautiful vengeance which would result from the sacrifice of his life.* The excitement in his household, the confusion caused by the news of his death, gave him a mournful and yet pleasurable impression. He ran over all the rooms in his thought; he saw the servants dressed in mourning and walking like shadows; *he saw his parents, livid with remorse, seated face to face, hating themselves and accusing themselves.* Yes, he would let himself die! He obsessed himself so completely with that great, overwhelming thought that he began to be moved by such an obscure and strange feeling that it seemed like a sensation from the other life. He recapitulated in his mind all of his previous memories and thoughts; he discovered in himself the seamless thread of another consciousness which when pursued too far merged into a circle of shadow. So vague an awareness was it and so near the fringe of forgetfulness that no remembrance of it could be retained in the normal state. Agila sang with harmony in half time, with the anguish of a child:

"I will let myself be killed! ..... I will kill myself!"

(Valle-Inclán: *La Guerra Carlista III Cerifaltes de antano*)

Tolstoy describes for us the motive for the suicide of Anna Karenina, the desire to avenge herself on her lover. He writes: "To her mind death was the only way of reviving his love for her, of punishing him ....Only one thing concerned her now: punishing him." "There, I will kill myself," she told herself (Anna Karenina), looking at the shadow of the wagon and the sand and smoke which covered the roads–, "there in the middle; I will thus punish him and free myself of everything, even from myself."

In many of the cases of suicide previously described in these pages, the aggressive desire of the suicide to avenge himself against the external environment, can be observed.(2) In order not to repeat the previous citations and at the same time to attempt to further investigate the psychology of suicide along new lines, it is now necessary to study aggression towards the external environment in some ethnographic settings.

Among some tribes of the Gold Coast, when an individual, just prior to committing suicide, attributes his desperate decision to the conduct of another person, this other individual becomes obligated to suffer the same death. This practice, based upon the tribal law, is called, "one's own death on another's head." Among the Tinklit Indians, a wronged person who is unable to avenge himself on his oppressor, commits suicide for the purpose of exposing the offender to the vengeance of kinsmen and friends. Among the Chuvaks (Simbirk, Russia) it was customary, a long time ago, for a person who was wronged, to hang himself at the very entrance of the domicile of the individual who wronged him. A similar method of vengeance is still in use among the Votiacos, who believe that the soul of the suicide pursues and haunts the offending individual. In China, suicide committed to take vengeance on an enemy and thus settle accounts with him is looked upon with favor and admiration. According to the Chinese philosophy this is the most effective system of vengeance not only because the laws

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To give the interpretation, punishing him and freeing herself of everything represents the aggression against the external world while killing herself to free herself from herself signifies the aggression turned against the ego.

In a novel by the humorist, Mark Twain, the hero feels mistreated by his parents. That feeling generates within him ideas of suicide having for their purpose, revenge on his parents. At one time he exclaims, "Oh, if one could only die for a short while!"

Mariano de Larra, in a comedy, *Spices,* considered by many to be a story which is symbolically autobiographic, tells us the motives of the hero's suicide in the following words, which the author put in the mouth of this main character and which the latter directs towards the woman he loves:

Unfaithful One

When you wish to forget me in his arms
my shadow will angrily arise between you and
your husband, and to your great horror,
still bespattered with blood.

In these words the aggressive feelings towards the woman can be clearly observed as they strive for realization through suicide.

In a translation of Scribe, made by Mariano de Larra and entitled *Love or Death,* the same suicidal motive is cynically described in the following dialogue:

Clot.—....You would not be able to kill yourself for a woman?
Mon.—Never!

charge the responsibility for the suicide on the person who caused it but also because it is felt that the spirit, freed from the clothing and impediment of the body, is better able than the living mortal man to pursue the enemy.(1)

(1) Data cited in the *Espasa Encyclopedia*, article on "Suicide," pp. 572 and 574.
Footnote continued from previous page

Clot.–Not even for your beloved!

Mon.–I would very much regret it and she might also, it seems to me. Because in the last analysis, the following dilemma exists for those crazy people who think of doing so ..... Either the woman I love must feel my death very much and in that case I am too gallant to give her the idea of repeating my suicidal act, or she must be indifferent to my death in which case it is clearly very stupid to furnish her with so dear a diversion.

In the *Aeneid*, Dido, contemplating suicide, exclaims:

"And when the cold of death has separated my soul from my body, then wherever you may be my shadow will follow you. *You must atone for your crime, miserable one.* And I will know it, because I will take that coveted knowledge with me in my wanderings through the profound depths of Hades!" (385).

Ariosto Licurzi, in his book, *The Suicide* (Buenos Aaires, 1942) cites a very illustrative case. He refers to a ballerina who, believing that she had been deceived by her husband, wrote him a letter announcing her approaching end and her vengeance to him: "You have made a perfect inferno of my life. You have lied to me from the first day. *My death will haunt your life.* I will always be pointing the accusing finger at you for the harm which you have caused me. May you be cursed!" Then she telephoned him and shouted at him: "Have you ever heard a shot over the telephone? Listen ...." And she shot herself.

Bernard Shaw ironically makes this psychological attitude clear in these words: "The sacrifice of ourselves permits us to sacrifice other people, without this we would have to blush with shame."

According to Dante, in the inferno, suicides are converted into trees, and as such, suffer the aggressions of the others wtihout being able to retaliate: "The Harpies feed themselves on the leaves, causing pain which the sinner feels" (Canto XIII). Thus, suicides are punished by making them submit to the very hostile environment from which they tried to escape and in addition by imposing on them the very aggression which they wanted to realize through their sucide.

On the other hand, guilt feelings as a result of having realized an intense aggressive act can lead to suicide. Continuing this line of thought, it can even be said that suicide is the most appropriate punishment for homicide. An example is the case of Judas. Also, that is the advice, according to Shakespeare, which Anna gave the criminal Richard III (Faust, Act. 2, Scene II).

> "Most mad individual that a human heart is capable of thinking of, you can only redeem yourself by committing suicide."

The intimate relationship between suicide and homicidal desires is further illustrated in other psychological works such as in mythological tales. One of the best known is that referring to the nymph, Calirrea,, who was beloved by a priest of Bacchus, Coreso, whose love she did not reciprocate. As a result, the despondent Coreso asked for the divine intervention of Bacchus who punished the compatriots of Calirrea with a type of fatal intoxication. According to an oracle, in order to placate the god it was necessary to sacrifice the nymph or any other person who would take her place. Thus, when Calirrea was about to be sacrificed, Coreso, penitent and remorseful, killed himself in order to have her. But, confronted with such a great proof of his love for her, Calirrea had no desire to continue living and also committed suicide.

The aggressive strength or force of the suicide directed against the external world, especially if it is a collective suicide, is so great that it is employed, at times, as a method of influencing the outcome of an important act, the fate of an army or the result of a war. Grasset relates that, a long time ago, in China, before the beginning of a battle, the bravest warriors destined for death were sent in front of the army . . . When they arrived face to face with the enemy they shrieked in loud voices and then cut their throats. A ferocious spirit was generated as a result of this mass suicide. This spirit was supposed to influence adversely and fatally the lot of the enemy.(1)

The great apprehension which the possible vengeance of the suicide engendered caused some peoples to utilize special procedures or rituals of various kinds to defend themselves. Thus, out of the fear of the aggressive power of the suicide arose the customs of nailing the corpse of the suicide against a stick or tree shoot planted in the earth, of decapitating the suicide, of amputating his extremities, etc. Thus, in the 14th century, the Anhenians would cut off the hand of the suicide and bury it in some place other than where the rest of the body was buried in order to hinder the deceased from avenging himself by making use of his hand.(2)

The suicide was feared, not only for his possible vengeance, but also because it served as a bad example. Thus, when someone hung themselves, the Wajagga tribe of Eastern Africa, would substitute for the corpse a goat which they hung as a sacrifice. They thought that this would calm the spirit of the suicide and it would then refrain from influencing others to follow its example.

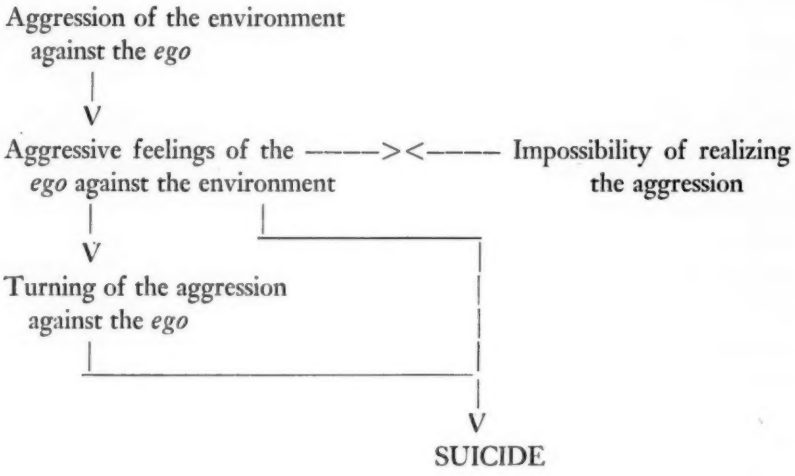
Many other peoples were accustomed to defend themselves from the persecution of the soul of the suicide by adapting a variety of procedures or rituals. In Pomerania and in East Prussia people who committed suicide were buried on the spot where they died and not in the local cemetery. Any individual who had to pass by such a grave had to throw a stone or a stick in order that the suicide would allow him peace of mind. The same type of ritual was followed by the Baganda tribe of Central Africa. In order to destroy its spirit or soul, they burned the corpse of the suicide together with the timber of the house or the tree on which he had hung himself. They took the additional precaution of

(1) Halbwachs: *The causes of suicide*, page 467.
(2) Frazer: *The Golden Bough. Adonis, Attis, Osiris*. Chapter IV, *The Hanged God*.

FRAGONARD: SUICIDE OF THE PRIEST CORESO

throwing herbs or a stick, each time they passed the site of the hanging or suicide. Women were most obsessed with a fear of being impregnated by the spirit of the suicide.[1]

Taking into account the additional data presented above, it is necessary to complete our diagram of the aggressiveness of suicide by adding direct aggression against the external environment as follows:



We have already seen how suicide serves as a method of satisfying the aggressive impulses caused by the environment. But it is also a way of recovering the lost libidinous object. Analyses of suicidal individuals prove that the act of killing themselves symbolically represents the libidinous object. For example, there is the case of the lover who commits suicide when his beloved dies, "in order to be with her eternally."

Nothing in the objective data of material reality exists to confirm the efficacy of this procedure for recovering the lost object. Our observations show us that the body of the suicide is destroyed in the same manner as that of his deceased beloved. We do not see, therefore, that suicide may be the beginning of happy eternal life. In spite of all this, there are certain aspects of suicides which clearly demonstrates that one of the motives which move them to commit suicide is precisely the de-

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[1] Frazer: *The Golden Bough. The Scapegoat.* Chapter I, *The transference of evil.*

sire to regain something lost or something desired which could not be attained by any other method.

In order to clear up this apparent contradiction, we must remember that when we make a psychological study we deal with psychic realities and not material realities. We will therefore examine this phenomenon further in order to exhibit proofs of its psychic existence without concerning ourselves with the faultiness of its reasoning or its lack of logic involved.

Continuing our ethnographic examples, we find ourselves with many instances of suicides motivated by the desire of recovering a libidinous object. Thus, we all are acquainted with descriptions of suicides of women after the deaths of their husbands. For example, in India the custom was for the widow to permit herself to be burned on the funeral pyre which consumed the corpse of her husband. This was done with the purpose of accompanying him into the other life. In 1827, in the province of Bengal alone, 706 widows committed suicide and in 1821, in all India, 2,366 women killed themselves in this manner. This is also a very common motive for suicide among savage peoples. M. Eckardt relates[1] that in the Solomon islands, in Melanesia, when a chief dies, the majority of his women consider it as an obligation to commit suicide. For this reason they poison themselves with the juice of a lethal plant and drape themselves about the corpse of their husband. And the motive of this suicide is, of course, the desire to accompany the husband into the after life and there furnish him with love and care.

This type of suicide motivated by the desire to recover the lost object does not only occur as a result of the death of a lover or mate but also happens in the case of the death of either parent or of a chief. Thus, Towner[2] describes how, in the New Hebrides, when a beloved child dies it is customary for its mother and an aunt to commit suicide in order to care for it in the other life. The practice of committing suicide after the death of a chief is also a very ancient custom. In some countries, as in Japan, it was legally recognized that when some chief died, his faithful subjects were obliged to accompany his soul to the kingdom of the shadows by killing themselves. This obligation on the part of the vassal to commit suicide on the death of the lord was abolished in

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(1) Cited by J. Wisse: *Selbstmord und Todesfurcht bei den Naturvölkern Zutphen*, p. 10, 1933.

(2) Wisse: *Selbstmord*, etc. p. 9.

Japan in the 18th Century but it continued to be practiced voluntarily even up to the present day.[1]

Another libidinous object for the recovery of which suicidal means are employed, is health or youth. Thus, in a solitary spot of the country of the Goths, a high, large rock was raised vertically, *die Stompklippe*, and people of that entire region would throw themselves from it into the abyss. They did this when they had been made bitter and felt oppressed by the environment or when they felt themselves bent down and helpless because of old age. They were motivated, in this act, by the belief that they were going to the domain of Oden where they would be freed of all illness or infirmity. Many other rocks of this kind existed, from which the old people threw themselves, believing that they would thus go to the land of eternal youth.[2]

At other times suicide was employed to prevent the loss of fame or glory or to achieve renown. This was the case with the old Prussian chiefs, the *Kirwaidos*, who would kill themselves, when they became old or ill, in order to leave a respected name to posterity. They would place themselves at the top of a funeral pyre of straw and shrubs and from there would exhort the people, asking them to honor the Gods before whom they promised to intercede. Then they would themselves light the bonfire on which they burned to death.

Many more examples could be cited both of an individual or collective nature. According to Lucianus, the buffoon Peregrius, after a life of knavery, burned himself to death at an Olympic festival before a multitude of admirers. Also, the Chinese Buddhist priests would sacrifice themselves in similar fashion in order to attain the good will of the community.

Ethnographic reports have demonstrated the existence of suicides motivated by the desire to recover a libidinous object in the following 71 peoples.[3] *Melanesia and New Guinea*: Fiji, Tana, Maewo, Solomon Islands, Sissanu, Kanomé, Orokaiva and Biakker; *Polynesia*: New Zealand, Tonga, Sandwich Islands; *Micronesia*: Yap; *Eskimos*: Northeast Greenland, Western Greenland, the Caribou and Iglulik Eskimos; *American Indians*: Chinook, Northeast Oregon, Western Washington, Schahaptin, Schuschwap, Selisch races, Wallah-Wallah, Semels, Bodegisch, Cree Sioux, Mandan, Iriquois, Hurons, Odschibwa, Saulters, Ot-

(1) Cited by Rost: *Bibliographie des Selbsmords*, Augsburg, 1927, p. 301.
(2) Cited by Rost: *Bibliographie*, etc. p. 49.
(3) Cited by Wisse: *Selbsmord*, etc. p. 486.

tawa, Naches, Comanches, Mohave, Apaches, Panama, Nata, Mosquito, Haiti, Paraguay, Lengua, Bororo and Macunis; *Bantu*: Barongo, Herero, Banyankole, Bangala, Gabun and Bakhiviri; *Sundan Negroes*: Dahome, Lower Niger, Gold Coast and Borgn; *Hamitas Peoples*: Teso; *Southern Africa*: Hottentots; *Malayans*: Kubu, Sekab, Poso-Alfuren, Bare'e and Toradja; *India*: Saoras and Wedda; *Northeast Asia*: Athka-Aleutes and Tchukschos; *Asia Minor*: Digores; *Primitive Europeans*: Tracos, Cetas, Teutons, Celts, and Russians.[1]

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[1] Some examples of suicides or suicidal attempts motivated by the desire to recover the lost libidinous object, taken from literature are the following:

Valle-Inclaw: *Stage of Marionettes*

MARI-JUSTINA

If you should find yourself in the presence of the king,
You would fancy yourself a maiden
Who wished to be married to death
so that you could love him happily from a star

The Lovers of Ternel, fourth act, scene X:

ISABEL

The heaven, which divides us in life,
will unite us in the tomb .....
.....My goodness, pardon
My fatal wrath. I adored you,
I was yours, I am yours; my enamored
spirit rushes in pursuit of you (She dies)

Alhalach (the mystic poet of Bagdad):

My friends, kill me,
For my life consists in my death

Don Quixote, first part, Chapter XXVII

Who will better my lot?
Death

Saint Teresa:

Behold that love is strong,
life, do not be vexatious,
behold that it only exists for you
to win you, to lose you
Come now sweet death

Saint John of the Cross:

This life which I live
is depivation from living

As can be seen from the *Dialogues* of Plato, death for Socrates also signifies the attainment of some more favorable libidinous objects:

No one knows what death is. Sometimes death is the greatest of all kindnesses . . It is impossible for us to be right when we think that death is an evil. Because being dead can be one of the following two things: either good because of not being anything, nor feeling anything, or, on the contrary, a transmigration of the soul from this earth to another place. And if it is true as has been said, that all the dead are in this

Then again, the method of suicide employed can itself be unconsciously symbolic of the recovery of the libidinous object even independently of a particular external object. Thus, in the study of the psychogenesis of a case of feminine homosexuality, Freud cites the case of a youth who attempted suicide by throwing herself from a height. In this act the fall had the unconscious significance of child-birth. (In Freud's mother tongue, German, to give life and to descend or fall are both expressed by the same word: *Niederkommen*, which also happens in the French: *Mettre Gas*).

When we take these facts into account we are better able to understand the preference of women for suicide by throwing themselves into the water or poisoning themselves, especially since such deeds frequently have the symbolic psychic significance of pregnancy or child-birth.[1] (See the Plate showing a gypsum mask of a woman who drowned herself. The facial expression presents an extremely placid appearance. The work is usually referred to as "The Unknown Lady of the Seine.")

The investigation of the psychological mechanisms which are at the basis for the belief in the recovery of the lost object by means of suicide would be extremely interesting. It would also aid in the solution of some additional problems with reference to the psychic basis of faith in immortality or survival after death in the religious individual. However, the limits of this work preclude our investigation of these phenomena at this time.

Footnote continued from previous page

other place, then tell me, judges; what greater good can exist than this blessing? Because on arriving to the other world one is freed from those evils called judges? And meets there the *true divine judges*. Is this an unfavorable change? I want to die at least a number of times if that is so.

[1] In the dream of one of our psychoanalytic patients, the act of committing suicide by throwing herself from a great height has the psychological significance of allowing herself to receive genital satisfaction. The dream is as follows:

"*I throw myself from the top story of my house (to commit suicide)*"

A diurnal interlude, which gave form to the dream, was the fact that she had seen a theatrical work the previous day, entitled, "*To Commit Suicide in Spring is Prohibited*." The work of interpretation showed that she threw herself from the upper floor of the house, which represented her head, to an interior courtyard, which symbolized her genital organs. She thus got rid of her psychic inhibitions and restored herself fully to sexuality. A woman who openly conducts herself in such unrepressed fashion is, in the common parlance, referred to as an individual who has "fallen low," so-called because the genital organs are situated "below."

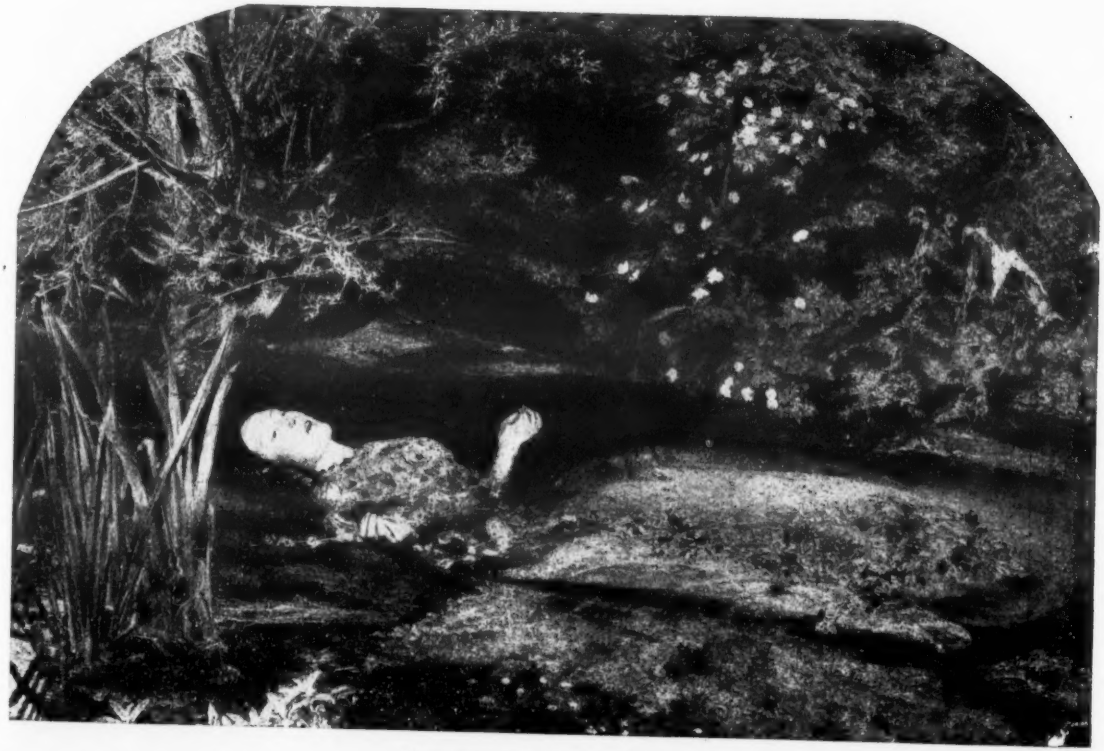
As further examples of suicide in which the two basic motivations of, aggression against the environment, and desire to recover the lost object, appear simultaneously as part of one unity, we cite two cases taken from literary works.

Shakespeare, after describing the rape of Lucretia by Targuinus, puts the following words into her mouth:

> The only remedy which can cure me is the forcing of my blood from my veins, hatefully blemished . . .
>
> I will bequeath my honor to the knife which slashes my dishonored body. *It is a mark of honor to put to an end a dishonored life, because when life ends, honor will still remain.* Thus my reputation will be freed from the ashes of my shame, and thus having killed my shame, my honor will remain of the world.
>
> Dear sir, what portion of the precious jewel which I have lost will I bequeath to you? My resolve, my love, will be your theme of pride *and the example which I set for you will show you what vengeance you must take.*

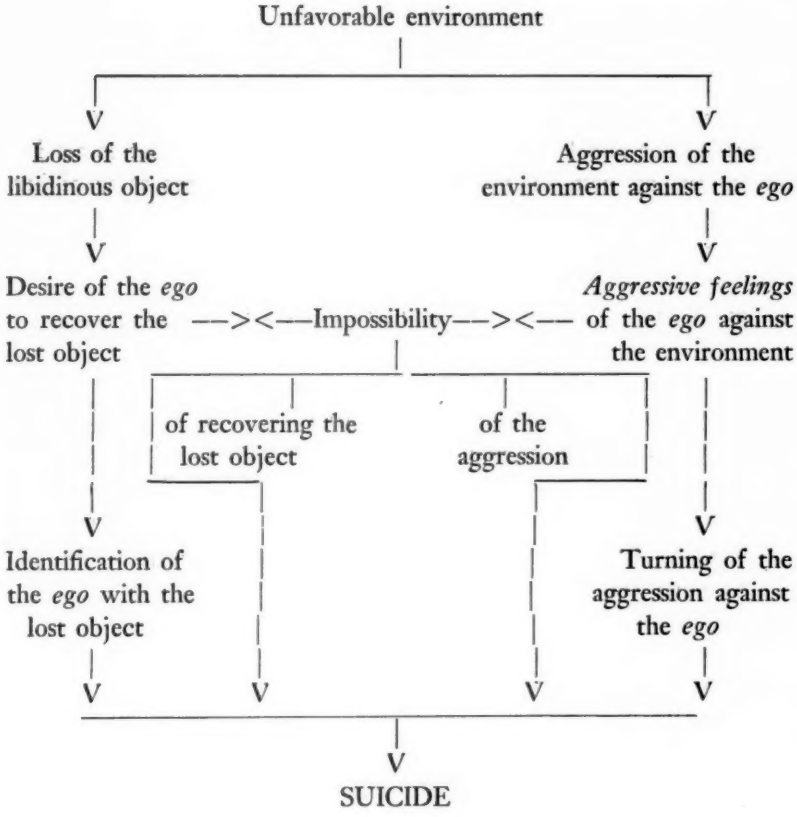
And in *La Celestina* (twentieth act):

> Melibea — I am forsaken by everybody; well, the manner of my death has been prepared; *I feel some relief in the knowledge that so soon we will be together, my beloved and adored Calisto and I.* I wish to close the gate so that nobody can surprise me to prevent my death or impede my departure, or block the road through which I will, in a little while, be able to visit today him who visited me last night. All has been done according to my will. In good time I will return to tell Pleberio, my sire (the father of Melibea) the cause of my self-inflicted end. *Great unreasonable one, I do things to your measures; great offense to your old age!* . . .



Unknown Lady of the Seine

If we incorporate these two motivations of suicide into those previously studied, we can complete our diagram in the following manner:



Infantile Experiences and Constitutional Factors

In every neurosis both actual conflicts and infantile conflicts intercur. The same phenomenon occurs in the psychogenesis of suicidal ideas; side by side with the actual motivations which oblige the individual to find life disagreeable exist the infantile motivations which have caused a masochistic distortion of the personality. These revived infantile conflicts cause the actual present conflicts to work on the individual with more intensity.

One of our patients frequently entertained ideas of suicide. Since we were interested in the study of the psychology of suicide, we asked her to describe to us, in a literary composition, the motivations which generated those despondent ideas within her. We placed no restrictions or other requirements on what the patient should write. She did, however, possess some special psychological knowledge. She was an intelligent woman who was gifted with a special capacity for psychic introspection and self-observation. In her attempt to describe to us the motivation for suicidal ideas, she spontaneously chose to discuss her infantile conflicts first. We will here reproduce verbatim some of her writings, restricting ourselves to those parts necessary for us in order to make a schematic psychoanalytic study of the patient.

She begins by narrating to us the loss of the libidinous object:

> Almost since the day I was first able to reason, I remember feeling an irresistible urge toward suicide. I was eight years old. I was in ————, a city in which I passed the bitterest and most painful period of my infantile existence. It was in this period when there was awakened in me the desire to make an end of a life which I believed to be unhappy and unattractive.

In the lines that follow the patient describes for us the aggression of the environment against her ego:

> I had ample reason for believing that the life which my brothers and I led was very unhappy. My mother mistreated us without mercy of word or deed. She was an intelligent, cultured and very beautiful woman with an extraordinary charm for those who did not know her intimately. Nobody, seeing such an attractive individual could have suspected her inhuman cruelty, her disdain for the weak, her refined methods of producing suffering of whatever category.
>
> She possessed a keen perspicacity and an iron will. With her strange instinctive capacity for learning each individual's most vulnerable point, and the precise place to wound and cause greater pain, she always had us terrified, defenseless, and completely submissive to her arbitrariness and despotic power.

DAVID: THE DEATH OF SOCRATES

Later, we can observe the beginnings of her aggressive feelings toward the maternal aggression but we also see that these feelings are repressed as in the following:

> At times, I came to feel a violent hatred toward her; but I admired her in spite of the fact that she had made me suffer, and I was so intimidated by her air of superiority, that she appeared to me to be an omnipotent being.

The strong guilt feelings cause the aggression to turn itself against the *ego*:

> I would see other children, friends and school companions, living sheltered lives of sweet unconsciousness. I would envy them and, activated by the unpleasantness of our situation, I came to believe that we did not deserve any other fate. My mother constantly humiliated us, making us think of ourselves as monsters without entrails, as the most evil creatures in existence. Our youth did not permit us to understand the injustice and mostrosity of her conduct. I would weep in unconsolable fashion and would always feel like asking for forgiveness. From this early conditioning, there was born within me, a deep humility, an inferiority complex, and a timidity which has always tormented me.
>
> The children in my family were all educated in such a way that they were instilled with the idea that the parents and teachers were never mistaken. As a consequnce of this type of education, the child, timid and certain of the parental infallibility, did not dare to form any judgments or opinions concerning the words and deeds of its parents. She had been told that they (the parents) were always right and that *she was nobody*,[1] and, consequently was unable to judge them. Her mission was to reduce herself to blind obedience or perpetual gratitude. Her parents did her a great favor by bringing her into this world; they gave her a daily demonstration of kindness in feeding her and educating her. If they punish her it is for her own good in order to curb her evil instincts and her innate perversion. Each blow, each wounding word, was a

(1) Patient's italics.

testimony of love which the poor child did not know enough to appreciate or be grateful for. The father, mother, teacher, all sacrificed themselves repeatedly while the child was an ingrate lacking in sensibility.

The aggression turns against the *ego* and revives infantile ideas of suicide:

Rendered hopeless by this state of inferiority in which I found myself, without support or counsel—children, in their need for security, do not know how to find solutions to their conflicts—, I began to toy with the idea of ending it all. But how?

Since I was a little girl I was given to dreaming and letting my imagination run away with me. I would shut reality out of my existence and fill my life with improbable fantasies which I invented in my moments of solitude. I was not afraid of death because, since nobody had spoken to me about the *great beyond*, I did not believe that another life, worse than that which I knew, could exist. Not having had any religious training I was ignorant of the sin and the eternal punishment which the church inflicts on the suicide.

Nevertheless, the aggression has not turned completely against the *ego*, but there is still a residue of sadism which follows the primitive drive twoard the outer world. This impels her to desire the death of others too:

However, I had a dread of dying alone. My most frequent dream was that the world would be destroyed with me, and this dream made me think of interplanetary catastrophes with pleasure. My father had given me a few lessons in astronomy. I, nevertheless, forgot what I had learned about mathematics in these lessons. I did not want to picture the heavenly bodies as traversing their orbits with the immutable organiation of cosmic laws.

I preferred to think that cosmic accidents could alter their path causing some to collide with others. For a long time, I was obsessed with the idea that our planet would be obstructed in its path by one of its companions. I felt the nearness of

> the monstrous thing; I saw it growing in stature each day. I also imagined the inhabitants of the Earth enraged and terrified in the face of the approaching catastrophe. What terrified me most was a sensation of coldness and of darkness which would invade the Earth. But the idea of dying, of ending it all without leaving even the slightest trace, consoled me in all my fears.

In the above lines and also in those that follow can be observed the masochistic distortion of the personality:

> As the desire to escape from my mother's despotic oppression over us became more violent daily, I became very fond of games which were somewhat dangerous since the emotion attached to this danger made me forget the constant anxiety in which I lived. I derived an enormous pleasure from seating myself at the edges of windows with my legs inclined toward the street. I was allured by the possibility of falling even though I knew that such a fall would be fatal since we lived on the fifth floor.

We will now present *another clinical case* in which can be observed clearly how the conflicts stirred up by infantile experiences can, after being revived and strengthened by present conflicts, lead to ideas of suicide.

It deals with a man of twenty-five years who made a suicidal attempt by inflicting several cuts on the veins of his arms with a shaving razor. When he was asked about the motivations for his attempted suicide, he answered that he found life of little interest, that he had to work too hard, and that he thought of killing himself because of these two reasons.

Actually for the past six months he had worked very intensely, for as much as fifteen or sixteen hours a day, in a business which went splendidly, from which he received a good salary and in which he was highly regarded by his superiors. He began work in the early hours of the morning and did not stop until late at night. He slept little and was not inclined at any time to take time off from his work and enjoy himself.

A real conflict situation therefore existed in this patient: the life of very hard work which caused a depressed state of mind. This depres-

sion impelled him to seek death. But the actual conflict, taken by itself alone, does not explain the suicidal attempt. Only by learning about the infantile experiences of the patient, in addition to the above actual conflict, can we adequately comprehend the psychology of his suicide. For this reason we will briefly review the history of the patient:

> T...., was a weak and sickly child. He very frequently suffered from an infantile form of asthma especially in the and autumn. At those times, he had a marked dyspnoea which prevented him from attending gymnasium or playing with his classmates. This illness also caused him to frequently be absent from classes. But T...., in spite of his bad health, tried to surpass his companions in school studies and sports.
>
> His parents treated him well but very strictly. They were people of rigid and serious habits. They would not permit their children more than a very few diversions and continuously tried to inculcate in them the notion that life consisted of the rigid fulfillment of duty.
>
> As a child, the patient's greatest love was football. He attended all the games even though he knew that, because of the frequent rains in the region in which he lived, he would suffer very frequent attacks of respiratory illness.

The rigorous familial training, coupled with constitutional weakness, masochistically distorted T....'s personality. This masochistic distortion greatly influenced his ultimate behavior, bringing him to the point where life lost all its attractions for him and where he subjected himself to too much hard work which he performed as an obligation from which he could not escape. His suicide was a way of solving all these conflicts.

> After completing his schooling, he went to work in the city of B...., performing his duties satisfactorily. He became a hockey player and in spite of the fact that his respiratory difficuties bothered him, he became a better player than his companions and was elected captain of the team.
>
> In B...., he also began to lead a crowded social life, attending many meetings and dances. However, his happiness in these diversions was not on a par with those of his compan-

ions, because with him the whole thing was somewhat forced and fictitious. He would also go out with girls but always tired of them rapidly. He would receive love letters from some which he would not answer.

At the age of twenty-three, he moved to P. . . ., where he found an excellent position. He worked hard and well, succeeding in improving his situation and winning approbation. His transfer to Madrid, five years later, was the result of the high regard in which his superiors held his work.

In P. . . . he became very intimately acquainted with one of his chiefs who was a man of his own age. He would attempt to participate in various social affairs in the company of this superior and his wife but he always maintained a level of seriousness out of keeping with his age. Only on rare occasions did he dare to amuse himself more freely but at those times he would also remain sad and in bad humor.

During this entire period he would become very depressed for days at a time. He would dream of something which he could not describe, which either would fall or weigh heavily upon him.

At the age of twenty-four, he experienced his first coitus with a prostitute and was normally potent. Subsequently, he again had intercourse, from time to time, always with prostitutes. After coitus he would feel dejected. With the exception of the above it never occurred to him to begin an intimate relationship with a woman.

He rarely visited his family from whom he lived apart. His letters to his parents were frequent but unemotional and lacking in appropriate intimacy.

T. . . ., accounted for the fact that his psychic state was getting worse by blaming it on his unhygenic manner of life. But—he told us—he continued this manner of living just as he had done with the football: in spite of the fact that it caused him damage, he did not modify his conduct.

At the age of twenty-eight, the patient was transferred to Madrid under the conditions already mentioned. Only T. . . . was able to complete the tremendous amount of work in the office because they didn't have any other employee who had the required specialized knowledge. T. . . . had some clashes with his superiors which he tried to escape.

> He felt very fatigued both physically and mentally. In view of the fact that he found no pleasure in continuing to live, he decided to commit suicide. He did not communicate his decision to anyone, not even his parents. He cut the veins of his arm with a razor blade; and the cuts "were quite extensive" in the patient's own words. T.... thought that he was going to die as a result but the wounds bled and after a time the hemorrhage finally subsided. He inflicted a number of cuts upon himself, "trying to catch important veins, such as that of the pulse." In view of the scant success of his attempts, he tried it with a rusty blade, thinking that the would inflict a greater wound and cause a more massive hemhorrhage of longer duration. He mutilated himself considerably by cutting himself in this fashion but it gave him pleasure to think that he would succumb to such a death. Some people who entered his rooms saw what he had done and took him to a hospital.

Another important factor which conditions the psychology of suicidal ideas is that of hereditary constitution. There are families whose members are irresistibly drawn toward suicide. However, we cannot on that basis alone conclude that suicide may be provoked by constitutional motivations. Maccabruni[1] describes a family in which none of the causes to which suicides are commonly attributed at the present time could be found. Neither economic difficulties nor violent passions, nor incurable illnesses were present and the members of the family appeared to be normal people from a psychological point of view. The second son was the first to commit suicide; a little later, his sister killed herself; four years later, the fifth child; and another four years later and the father took his own life. The daughter poisoned herself with phosphorus and the others shot themselves all with the same pistol. Twelve years later a grandson killed himself.[2]

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[1] Cited by Rost: *Bibliographie des Selbstmordes,* p. 133.

[2] Nevertheless, the value of the constitutional heritage as an explanatory cause of suicide must not be exaggerated. It is certainly one factor, but only one. To reach the conclusion that a given constitutional make-up constitutes the entire motivating cause of a suicide is to run away from the problem that this phenomenon poses for us.

Let us cite an example of such an absurd overemphasis of the supposed constitution: In order to explain the difference between the rates of suicide among Catholics and Protestants, A. Wagner states that even though "the external characteristics between the two groups differ little, still, there are essential differences between Catholics and Protestants in their psychic processes because of dissimilar brain structure and cerebral formations." This assertion can be matched with another made by A. de Ottingen. With

We had occasion to observe a family background, similar to the one described by Maccabruni, in a case studied at the Reformatory of the Tutelar Tribunal for Minors in Madrid. The patient was a seventeen-year-old boy, I. O., who was committed to the Tribunal for Minors several times for running away from the parental home and for various robberies and thefts. While incarcerated he made several attempts to commit suicide by slashing the veins of his arm. The family antecedents, according to data submitted by the boy's mother were as follows:

Paternal line—The informant could give no information concerning the *paternal grandfather's parents* or the *paternal grandmother's father.*

The *paternal great grandmother* was always a happy and contented person, "with whom it was a pleasure to deal." She drank brandy—frequently became intoxicated, and then sang and danced. She died at the age of eighty-nine.

A *brother of the paternal grandfather*, for a number of years suffered from painful nervous stomach ailments. He would take morphine injections to ease the pain. At the age of sixty he shot himself in front of a mirror.

A *brother of the paternal grandmother* poisoned herself with wax tablets after his wife had died and he became depressed.

The *paternal grandfather* was a person of disagreeable character with a violent temper. He was spiteful and always tried to take revenge on various people. He would beat his wife. He was constantly drunk. He did work as a printer and managed to perform his work well.

The *paternal grandmother* was a quiet person, of good character, who was very fond of her children but was submissive and of a very sad temperament. She had suicidal tendencies which she justified as a reaction to her husband's irascible conduct.

The *father* "is a maniacal, neurasthenic person. The informant knew him since he was eleven years old. When one meets him for the first time he gives the impression of being a very agreeable individual but soon his peculiarities become evident. He would frequently become violently angry and would brutally beat his wife. He would easily become jealous at the slightest pretext. He was not very sociable and had no friends because he would always be angry with everybody. When the parents were first married he gave up alcohol because of the disgust it created in his family but after two or three years of marriage (at the age of twenty-three or twenty-four) he again began to drink heavily and was inebriated almost daily and he still continues this practice at the present time. He is very jealous and suspects everybody. For example, he accuses a friend of his who is his son's godfather of being the actual father of his son. At other times he recognizes the absurdity of his suspicions and begs for forgiveness by weeping. One time his suspicions were so strong that he denounced his wife in court. When his wife converses with other people, he thinks that she is telling them bad things about him. He has attempted to kill his wife and himself afterwards.

Three Paternal Uncles. One died in childbirth. Another died at the age of twenty-nine of a cardiac embolism. He was very nervous and would tear his hair when his mother scolded him or made some complaint about him. One paternal uncle still sur-

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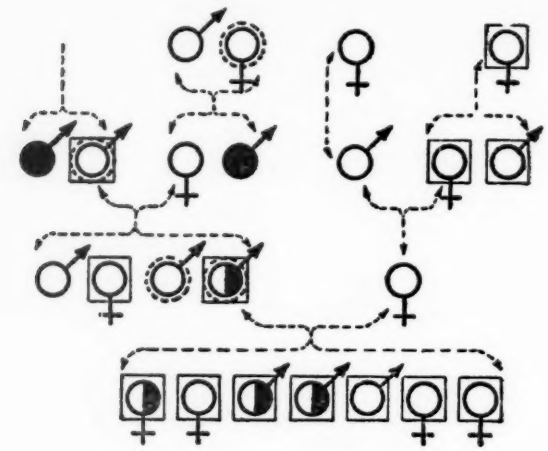
Note continued from previous page
reference to the same phenomenon of the greater frequency of suicides among Protestants than among Catholics, this author affirms that "The German with his great culture and his very profound sentimental life, the Protestant, with his tendency to doubt, is more prone to commit suicide than the frivilous and sanguine Latin who finds, in his church, if he has faith in it, a sure insurance against suicide."



KEY

Chronic Alcoholism

Suicide

Attempted Suicide

Psychopathy (exclusive of alcoholism and suicide)

vives. He is a very quiet person but is also fond of wine. However, instead of becoming violent when he drinks he sings and jests.

Maternal line—The informant did not know the *mother of the maternal grandfather or the father of the maternal grandmother.*

The *mother of the maternal grandfather* died at the age of eighty-nine and was a happy person who was never sad.

The *mother of the maternal grandmother* "washed her feet after two days of childbirth and had peculiarities and manias from that time on." The informant could not state in detail what her precise abnormalities were.

The *maternal grandfather* liked to attend the theater frequently and enjoyed doing so very much. He was very happy but not to excess. Also, he was very sociable, never hit his children and behaved quite well towards his wife.

The *maternal grandmother* was a happy, quiet individual. Her only peculiarity was that even in her late years, (she died at the age of ninety-five) she would curl her hair, put flowers in her hair and powder herself excessively but not to the extent of its becoming disturbing to other people.

The *mother* is a calm person who states that she has been disgraced very much by the characer of her husband. She recognizes the pathological family background of this boy and attempts to make the best of it. She married at the age of eighteen and often wanted to separate from her husband but did not do so out of social considerations.

A *maternal uncle* "was lost track of." He deserted from the army several times and nothing more is known about him.

There were *fourteen siblings,* only six of which are still alive. The others died in infancy or early childhood. In addition, the mother had two miscarriages.

The siblings are all psychopathic individuals of irritable and emotionally unstable character. They quarrel frequently among themselves at the slightest provocation and they remain angry at each other for long periods of time. They frequently hit each other in the head and throw things at one another. When something disagreeable happens they threaten to commit suicide and have actually made several attempts at suicide. All have the same type of temperament although in the two minors, five and nine years old, this has not yet been clearly demonstrated.

The oldest, G., is married and has no children.

E., twenty years old, is married and has two children. His character and personality have improved after marriage.

J., nineteen years old, is very nervous. He has spasmodic tics for which he receives medical treatment. As a child, he was subject to convulsions which did not appear in adulthood. He loves his mother but calls her "old eccentric." He is a bootblack and has no male or female friends.

I., seventeen years old, is an inmate of the reformatory.

J., fourteen, is very disobedient and frequently fights with his friends.

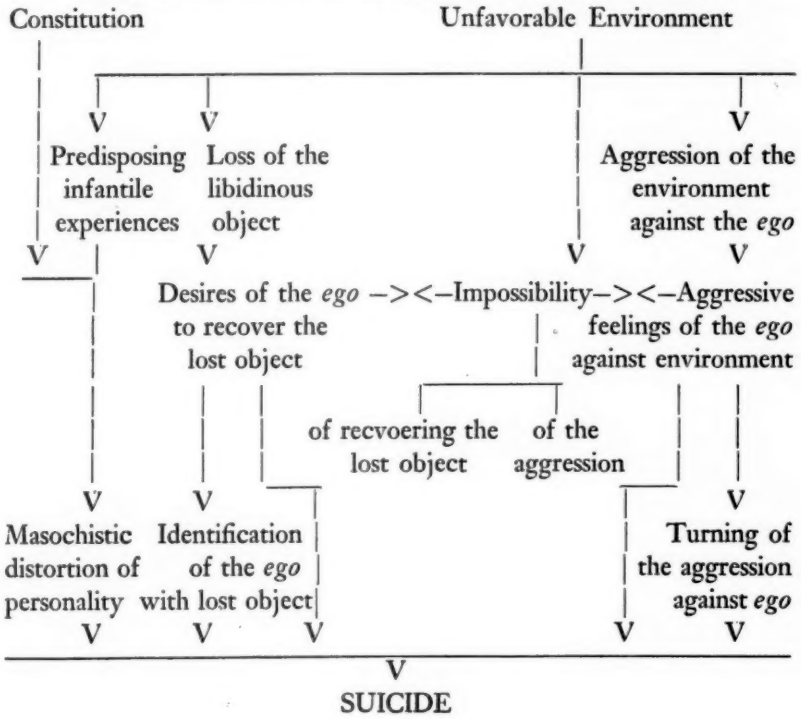
G., nine years old.

L., five years old.

Conclusion

To summarize all the data which we have presented concerning the psychogenesis of suicidal ideas, we can trace the following final diagram:

DIAGRAM OF THE PSYCHOLOGY OF SUICIDE



BIBLIOGRAPHY

Freud, Sigmund: *Zur Einleitung der Selbstmord-Diskussion. Schlusswort* Gesammelte Scriften, volume 3 (Neue Auflange, volume 8) 1910.

Freud, Sigmund: *Taner und Melancholie.* "Gesammelte Schriften," vol. 5. (Neue Auflange volume 10), 1916.

Freud, Sigmund: *Psychogenesis of a case of feminine homosexuality.* Complete works of Sigmund Freud, Volume 13.

Friedlander: *On the longing to die.* International Journal of Psychoanalysis volume 21, p. 4, 1930.

Menninger, Karl A.: *Psychoanalytic Aspects of Suicide.* International Journal of Psychoanalysis, volume 14, p. 3, 1933.

Menninger, Karl A.: *Lokalisierte Selbstvernichtung. Selbstverstümmelung.* Intern. Zeitschr. f. Psychoanalysis, volume 21, p. 99, 1935.

Friedman, P.: *Sur le suicide.* Revue francaise de Psychoanalyse, vol. 13, p. 106, 1935.

Zilboorg, Gregory: *Zum Selbsmordproblem.* Intern. Zeitschrift für Psychoanalyse, volume 21, p. 100, 1935.

Zilboorg, Gregory: *Suicide Among Civilized and Primitive Races.* Amer. Journal of Psychiatry, volume 92, p. 1347, 1936.

Schmidelberg, Mellita: *A Note on Suicide.* Intern. Journal of Psychoanalysis, volume 17, p. 1, 1936.

Bischler, W.: *Selbsmord und Offertod.* Imago, volume 22, p. 177, 1936.

Peller-Ronbiczek, L.E.: *Zur Kenntnis der Selbsmordhandlung. Psychologische Dentung statistischer Dater.* Imago, volume 22, p. 1, 1936.

Peller-Ronbiczek: *Consideration on Suicide with particular reference to that of the Young.* Amer. Journ. of Orthopsychiatry, p. 7, 1937.

Peller-Ronbiczek, L. E.: *Man Against Himself.* Harcourt, Brace & Co., N. Y. 1938.

Warburg, Bettina: *Suicide, Pregnancy and Rebirth.* Psychoanalytic Quarterly, vol. 7, p. 490, 1938.

Warburg, Bettina: *The Sense of Immortality.* Psychoanalytic Quarterly, volume 7, p. 171, 1938.

Brill, A. A.: *The Concept of Psychic Suicide.* Intern. Journal of Psychoanalysis, volume 20, p 314, 1939.

(To be Continued)

Proceedings

...of...

The Association for the Advancement of Psychotherapy

OFFICERS

PRESIDENT: FREDERIC WERTHAM, M. D.

VICE PRESIDENT: JOSEPH WILDER, M. D.

SECRETARY TREASURER: EMIL A. GUTHEIL, M. D.

The official fall season of *The Association for the Advancement of Psychotherapy* opened with the Scientific Meeting held on Friday, October 27, 1944, at the Academy of Medicine Building, 2 East 103rd Street, New York.

The paper of the evening was "The Origin and Evolution of Bisexual Differentiation – Special Reference to Medical and Social Problems" – and was read by Dr. Edward J. Kempf.

In the discussion that followed, Dr. William Wolf, Dr. Paul Federn and Dr. Emil A. Gutheil participated.

Dr. Wilder presided.

Dr. Kempf's paper will appear in this Journal at a later date.

* * *

At the meeting held on November 24, 1944, the Counsel General of the Association, Mr. Alfred Feingold, delivered a paper under the title "The Psychiatric Expert and the Law". Dr. N. Fodor, Dr. G. Blass, Lt. Col. R. H. McCormack, Dr. Wm. Wolf and Attorney S. Backlar participated in the discussion that followed delivery of the paper.

Dr Emil A. Gutheil presided.

* * *

The next meeting is scheduled to be held on Friday, Dec. 15, 1944, when a Symposium on "Genecology and Psychotherapy" wil be held. The speakers will include Dr. Walter Fuerst, Dr. Karl Kautsky, Dr. A. M. Hellman, and others to be announced.

* * *

Friday, January 26, 1945, the Association will hold a Symposium on "Gastro-Enterology and Psychotherapy". Speakers: Dr. F. Luft, Dr. A. Bassler and others.

Friday, February 23, 1945, the Association's meeting will be devoted to a Symposium on "Endocrinology and Psychotherapy". Details will be announced at a later date.

* * *

The Seminar of Dr. Lewis A Wolberg, on "Hypnosis as an Adjunct to Psychotherapy", which began October 5, 1944, comes to a close in December 1944; this Seminar is very well attended.

The next seminar on the schedule of the Association is one to be held by Dr. Joseph Wilder on "Psychosomatics" (10 hours).

The seminar by Dr. Ernest Harms on "Play Diagnosis and Play Therapy" (10 hours) is scheduled to begin January 15, 1945 and to end March 30, 1945.

Dr. William Wolf's and Dr. Emil A. Gutheil's seminars, (to be announced) will follow.

* * *

The Association plans a dinner to commemorate the fifth anniversary of the founding of the Association, to be held early in March 1945.

* * *

Physicians who wish to join the Association or to attend seminars and lectures may apply to the Secretary, Emil A. Gutheil, M. D., at 16 West 77th Street, New York 24, N. Y.

Announcements

The NATIONAL COMMITTEE ON ALCOHOL HYGIENE, Inc.

On September 14, 1944, The National Committee on Alcohol Hygiene, Incorporated, with national headquarters in Baltimore, Md., held its first institute on this major community and national health problem. About 700 representatives of Baltimore's professional and civic life attended. At the afternoon session, Robert V. Seliger, M. D., Executive Director of the Committee, instructor in psychiatry at the Johns Hopkins University Medical School, and Medical Director of the Farm for Alcoholic Patients, Ellicott City, Maryland spoke on "The Effects of Alcohol on the Individual." "New Approaches to Understanding the Alcoholic" was discussed by Lawrence F. Woolley, Clinical Director of Psychiatry, Sheppard and Enoch Pratt Hospital, Towson, Md.; Wilson Shaffer, Ph. D., Dean, College of Arts and Sciences, Johns Hopkins University; and Victoria Cranford, Rorshach worker and psychotherapist, Haarlem Lodge, Catonsville, Md. Robert M. Lindner, Ph. D., U. S. P. H. S. psychologist and psychotherapist at the U. S. Penitentiary, Lewisburg, Pa., spoke on "Alcoholism and Crime."

Supper group meetings further discussed the problem as viewed by social service workers, by probation authorities, and by the clergy. At the evening session, Samuel Hamilton, M. D., president-elect of the American Psychiatric Association and Director of the Hospital Division of the National Committee for Mentail Hygiene, presided. Among the speakers were Robert V. Seliger, whose topic was, "Alcoholics Are Sick People;" Lawrence Kolb, M. D., Director, Mental Hygiene Division, U. S. P. H. S.; and Haven Emerson, M. D., professor of Public Health, Columbia University, New York. Dr. Emerson spoke on "Alcoholism and Public Health", and Dr. Kolb discussed this problem as it is viewed by the United States Public Health Service.

Members of the National Committee on Alcohol Hygiene, Inc., are:

V. C. Branham, M. D., Supt. Woodbourne Institution for Defective Delinquents, Woodbourne, N. Y.

Brooks Branon, M. D., physician, Criminal Insane, Spring Grove Hospital, Catonsville, Md.

Caroline Diggs, B. A., head medical social worker, U. S. Marine Hospital, Baltimore, Md.

Robert H. Felix, M. D., Director, Mental Hygiene Division, U. S. P. H. S., Bethesda Station, Washington, D. C.

Maurice D. Friedman, M. D., neuropsychiatrist, Mt. Sinai Hospital, Cleveland, Ohio.

W. Horsley Gantt, M. D., associate in psychiatry, Johns Hopkins University Medical School, Baltimore, Md.

Florence Halpern, M. A., Rorschach worker and psychologist, Bellevue Hospital, N. Y.

Leo Kanner, M. D., associate professor of psychiatry, Johns Hopkins University Medical School, and Director, Children's Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, Md.

Edwin J. Lukas, Director, Society for the Prevention of Crime, N. Y.

Wendell Muncie, M. D., associate professor of psychiatry, Johns Hopkins University Medical School, Baltimore, Md.

Abraham Myerson, M. D., clinical professor of psychiatry, Harvard University Medical School, Cambridge, Mass., and Clinical Director of Research, Boston State Hospital, Boston, Mass.

Lt. Commander Florence B. Powdermaker, M. C. U. S. P. H. S. (R), Chairman of Medical Education, RMO and United Seamen's Service, N. Y.

Esther L. Richards, M. D., associate professor of psychiatry, Johns Hopkins University Medical School, and psychiatrist-in-charge, General Psychiatry, O. P. D., Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, Md.

Horace K. Richardson, formerly Medical Director, Riggs Foundation, Stockbridge, Mass., and consulting psychiatrist, Baltimore, Md.

Lowell S. Selling, M. D., Director, Recorder's Court Psychopathic Clinic, Detroit, Mich.

Wilson Shaffer, Ph. D., Dean, College of Arts and Sciences, Johns Hopkins University, Baltimore, Md.

Executive staff:

Director, Robert V. Seliger, M. D.

Director of Editorial and Educational Projects. Robert M. Lindner, Ph. D.

Director of Clinical Investigators, Lawrence F. Woolley, M. D.

Director of Scientific Investigators, Victoria Cranford.

The purpose of this group of medical workers is to disseminate scientific information to the public through various *educators* on the subject of alcoholism with the primary view of *educating* individuals and the community about alcoholism – as distinguished from social drinking – and the significance of this medical-psychiatric problem in its effects on, and relation to, both the individual and the community.

This group definitely is neither wet, dry, nor damp. Feeling that, obviously, one cannot have alcoholism without alcoholic beverages, these scientists also feel strongly that the personalities addicted to (or ready to be addicted to) the narcotic, – alcohol, whether as an escape or crutch, have alcoholism as a secondary illness-symptom and total-personality habit. Excluding clearcut psychiatric reaction types who may drink to excess, the fundamental difficulty is a psychiatric problem of *un-or-mal*adjusted personality-organizations with faulty values and attitudes and goals in life. Many stresses and strains in these times, and in the individual himself, contribute greatly to producing alcoholism – the culminating, overt sign of inward difficulty, disharmony, and illness. Thus, merely to take away alcohol begs the question. If those who clinically are found to have an alcohol problem could not obtain alcohol in any form – nevertheless, continuing to present a psychiatric problem – they would seek some other means of narcotization or escape, and thus prolong and postpone remedial measures for the basic conflict and illness.

At this first institute held under the auspices of this committee, speakers and discussants concurred that alcoholism is definitely a major health problem, directly and indirectly affecting the lives and well-being of many other individuals; and that this problem needs to be met by vigorous nation-wide, concerted scientific prophylaxis and diagnostic-treatment facilities.

To this end, *The National Committee on Alcohol Hygiene, Inc.*, is cooperating wiht other groups in the country who have similar purposes. At the present time, the following services and educational aids are

available through headquarters of The National Committee on Alcohol Hygiene, Inc.:

1. ALCOHOL HYGIENE – a bi-monthly bulletin-publication presenting material to be used for *educational* purposes.

2. Scientific medical-worker speakers for lay and other seriously-minded students of alcoholism.

3. A research staff to organize and sponsor institutes.

4. A clearing-center for proper evaluation of published material by the scientific research committee and for distribution of acceptable reprints.

5. Consultation service for Community Chest and other groups to aid in the organization of medically and psychiatrically supervised diagnostic-treatment alcohol clinics.

6. Material on fundamental preventive measures based on practical medical psychiatric knowledge and experience; and on actual treatment of individuals with an alcohol problem.

National Headquarters and Editorial Offices of The National Committee on Alcohol Hygiene, Inc.: 2030 Park Avenue, Baltimore (17), Maryland.

The MEDICAL CORRECTIONAL ASSOCIATION, an affiliate of the American Prison Association, participated in the Annual Corrections' Congress which was held at the Hotel Pennsylvania, New York City from October 12th through October 15th.

Psychiatrists, psychologists, social workers and others – all associated with penal and correctional institutions throughout the country – attended the session of the MCA which was held on October 12th. At that time presentations were made, and very lively, profitable discussions were held upon the following subjects:

1. *Alcohol and Crime*, by Mr. Edwin J. Lukas, Director, Society for the Prevention of Crime; Discussant: Dr. Gregory Zilboorg, Psychiatrist and Psychoanalyst, New York City.

2. *Integration of Psychiatric Service with Court Procedures*, by Dr. Lawrence F. Wooley, Clinical Director, Sheppard and Enoch Pratt Hospital, Towson, Maryland; Discussant: Mr. James J. Grout, Chief of Probation, U. S. Courts, Washington, D. C.

3. *What the Psychiatrist Wants from the Social Worker,* by Dr. Robert V. Seliger, Assistant Visiting Psychiatrist, Johns Hopkins Hospital, Baltimore, Maryland; Discussant: Mr. Frank Loveland, Assistant Director, Bureau of Prisons, Washington, D. C.

4. *Treatment in the Post-War Prison — From the Point of View of the Psychiatrist,* by Dr. Marion R. King, Medical Director, Bureau of Prisons, Washington, D. C.; *From the Point of View of the Psychologist,* by Dr. Benjamin Frank, Superintendent of Vocational Education and Training, Bureau of Prisons, Washington, D. C.; *From the Point of View of the Physician,* by Dr, John W. Cronin, U. S. Public Health Service, Washington, D. C.; Discussant: Dr. V. C. Branham, Superintendent, Woodbourne Institution for Defective Delinquents, Woodbourne, New York.

5. *Hypnoanalysis in the Treatment of Psychopathic Characters,* by Dr. Robert M. Lindner, Psychologist, U. S Public Health Service (R), Lewisburg, Pennsylvania; Discussants: Dr. Charles Fisher, U. S. Marine Hospital, Ellis Island, New York; Dr. Leslie H. Farber, U. S. Marine Hospital, Norfolk, Virginia.

6. *Tension, Its Study and Possible Role in Neurotic and Anti-Social Behavior,* by Dr. John D. Reichard, Medical Officer in Charge, U. S. Public Health Service Hospital, Lexington, Kentucky; Discussant: Dr. Frank J. Curran, Senior Psychiatrist, Psychiatric Division, Bellevue Hospital, New York.

The meeting was preceded by a business session at which the following officers were elected:

President, Dr. Robert V. Seliger, Visiting Psychiatrist, Johns Hopkins Hospital, Baltimore, Maryland.

1st Vice President, Dr. Robert Felix, U. S. P. H. S., Division Mental Hygiene, Bethesda Station, Washington, D. C.

2nd Vice President, Dr. Robert M. Lindner, U. S. Penitentiary, Lewisburg, Pennsylvania.

Secretary-Treasurer, Edwin J. Lukas, Executive Director, Society for the Prevention of Crime, New York 10, New York.

Councillors: Dr. Edward C. Rink, U. S. P. H. S., Lewisburg, Pennsylvania; Dr. Lawrence F. Woolley, Clinical Director, Sheppard and Pratt Hospital, Towson, Maryland; Dr. Dorothy G. Sproul, U. S. P.

H. S:, Alderson, West Virginia; and Dr. John D. Reichard, Medical Director, U. S. P. H. S. Hospital, Lexington, Kentucky.

THE NATIONAL COMMITTEE FOR MENTAL HYGIENE has announced the publication of a new directory of psychiatric clinics and related facilities in the United States, with special reference to rehabilitation needs of veterans.

This directory is broader in scope than any previous ones, according to the Committee. It is primarily for medical officers and other professional staff in the armed forces and the American Red Cross, who advise men about to be discharged regarding sources for psychiatric treatment and related services. It is also for the use of professional workers in civilian agencies in advising clients or referring persons to agencies in any part of the country. The directory lists state-wide facilities, such as state hospitals and other institutions for the mentally handicapped, state departments dealing with clinics, state societies for mental hygiene, Veterans Administration neuropsychiatric hospitals, and Veterans Administration regional offices; community psychiatric clinics and other resources, listed by state and city; family welfare societies; councils of social agencies; American Red Cross Home Service agencies, etc.

Latin American News and Comments

by S. B. KUTASH

Dr. Rodolfo J. Guiral, president, and Dr. José Bustamente, secretary, announce the founding of the *Cuban Society of Neurology and Psychiatry*. The purpose of the new organization is 'to maintain high standards in neurology and psychiatry and to cooperate in the psychiatric activities of our continent, bending our best energies to that end, and hoping that a close relationship may be established between the professional groups of our two countries."

* * *

The *Society of Psychopathology, Neurology and Legal Medicine* of Bogota, Columbia, has just conferred upon Drs. Nerio Rojas and José Belbey, the title of Honorary Corresponding Member from Argentina.

* * *

The Third Regular Meeting of the *Society of Legal Medicine and Toxicology* of Argentina was held on June 14, 1944 in Buenos Aires. Among the papers presented was a timely discussion of "Medical and Legal Responsibility in Convulsive Shock Therapy". Seven fundamental precautions were suggested by the authors, Drs. Belbey, Oliglio and Saralegui, which must be applied in all cases selected for these newer methods of treatment by electric shock, insulin shock and pharmacological shock, in order to prevent medical "accidents" and resultant legal liability on the part of the physician or hospital.

* * *

The authoritative and monumental work, "*The Criminalist*" by the renowned Spanish criminologist, Luis Jiminez de Asua, has been republished in an augmented and revised second edition by "*La Ley*" *Publishers* of Buenos Aires. Volume IV, just off the press, is entitled, "The Origin of Liberal Penal Philosophy". Other topics covered are "Prostitution and Crime", Alcoholism and Criminality", and "Public Penal Law". The works of Luis Jiminez de Asua have long been regarded as basic to an understanding of present-day Latin American criminology and criminal psychopathology.

Dr. Eduardo F. Belaustegui, one of the most prominent members of the Medical Board of the Federal Courts of Argentina, died on August 11, 1944 at the age of 70. He served as medical consultant to the Board on medico-legal matters since 1927 and was well known for his activities in the field of legal medicine in Latin America. A biographical note, special article, and photograph appear in the August 1944 issue of "*Archivos de Medicina Legal*" of Buenos Aires.

* * *

The *Losada Publishers*, Alsina 1131, Buenos Aires, announce the publication of a new edition of the classic work of Dr. Luis Jiminez de Asua, entitled, *Criminal Psychoanalysis*. Few specialists devoted to the study of penal science enjoy the prestige and renown which Luis Jimenez de Asua enjoys in the Spanish speaking countries. Formerly connected with the University of Madrid as professor of penal law, he now occupies the same chair in the University of La Plata. He holds honorary doctor's degrees from such South American universities as Lima, Rio de Janeiro, Bolivia and many others and before his arrival in the Western Hemisphere he was greatly honored throughout Europe. In *Criminal Psychoanalysis* the distinguished author objectively evaluates the interpretations of crime and penology enunciated by the Freudian and Adlerian schools. He points out the similarities between the two schools of psychoanalysis and quotes from the most recent writings in the English as well as the Spanish language. While agreeing with the psychoanalysts in considering the primitive methods of crime control and the prison as inadequate to prevent delinquency, the author, nevertheless, puts forth the thesis that psychoanalysis, by itself alone, can not discover all the causes of crime nor can it be the only prophylactic treatment of delinquency. The work includes a bibliography of hundreds of titles and is by far the most complete work extant in this field.

* * *

The *International Spanish-speaking Association of Physicians* was founded in the year 1926. The object of the Association is to create a fraternal relationship and unity among the allied professions all over the world and particularly with those of the Latin American countries, by promoting a scientific or social interest, by means of lectures, congresses, and the publication of the International Medical Blue Book Journal, the official organ of the Association, edited in seven languages.

On November 24, 1944, the Association inaugurated the nineteenth season of scientific sessions. For the past years the Association grew rapidly, becoming an International Institution, in addition to the Chapter-Magnum New York (which is limited to 1000 members) also forty-six chapters in the University cities in the U. S. A. and in all the capitals of the democratic nations with the chiefs of those governments as Honorary Presidents. The membership in the chapter is unlimited and consists of professors from various universities in the U. S. A. and in those all over the world. Further information regarding the Association may be obtained by communicating with Dr. J. M. Gershberg, Secretary, 125 Riverside Drive, New York City.

Abstracts From Current Literature

A - Psychoanalysis

SOME ASPECTS OF A COMPULSION NEUROSIS IN A CHANGING CIVILIZATION. HENRY LOWENFELD. *The Psychoanalytic Quarterly*, 13:1-15, No. 1, January 1944.

The author analyzed the case of a successful businessman, thirty-five years old, who was suffering from what was classified as compulsion neurosis. Among his complaints were: anxiety, depression and aggressive impulses, directed against his wife and their son.

The patient had been the only boy in his family with one sister older and two others younger than himself. He was on good terms with his mother but hated his father by whom he felt neglected and whom he regarded as a tryrant. The fact that his father beat him frequently aroused fear and terror in him.

The patient recalled particularly three nightmares he had in his childhood. The contents of all of them had to do with the relationship between something very big and something very small, "such as a giant ball and a small one."

When he was about eighteen years old, the patient became a member of the Communist Party, which he served with complete devotion. In the course of events, however, and particularly through the Moscow trials, he lost his belief in the cause and deserted it. This fact was important in precipitating his neurosis.

Another contribution to the outbreak of his illness was made in later years by a change in his father's attitude. The tyrant turned into a weak, helpless individual, who was dependent upon his son. Although the patient generally maintained an attitude of indifference toward his father, he occasionally had violent outbursts of rage over small matters, followed by feelings of guilt. Though essentially he was a sensitive and rather soft-hearted person, the patient was incapable of showing any affection for fear of appearing small and weak. Both these feelings of guilt and inferiority were intensified by the father's attitude because on the one hand he did not give him any real reason for his rage and on the other because he offered him the opportunity to express affection.

The patient's illness manifested itself in the fact that the nightmares he had had as a child now returned and tortured him during the day. The sight, or even only the thought of any particularly large object and its relationship to a smaller one would bring about attacks of anxiety. The most severe attacks occurred when he looked into space or envisaged anything that was not tangible or had definite limits, such as the ocean or the sky. These experiences are termed "cosmic fear" by the author.

In his effort to overcome this fear of the infinite, the patient had developed phobias and reaction-formations which found their expression in an unshakable scepticism and his refusal to believe anything that he could not see with his own eyes, or that was not tangible. Money became the center of his fantasies: "it was conceivable in finite figures" and at the same time it had the power to satisfy his desire for good, substantial and durable things, such as an automobile, or a particularly fine suit. A conflict now ensued between his craving for the security a saved sum of money would offer him and between his desire to overcome his feeling of inferiority through the possession of material goods. The realization, however, forced upon him in his business dealings, of the actual insecurity of money in the present time, deprived his possessions of their protective value and his old fear would again arise. Consequently, his entire inner stability became dependent upon the fluctuations of the very reality into which he had fled.

Accounts of accidents held a strange fascination for him and he particularly remembered one to which he had been witness: a man had been run over by a large truck. Here he was actually confronted with the conflict of "the big and the small."

His reaction to the war was identical. In the struggle between the nations he saw a reflection of his own inner life: insecurity, violence and destruction. There also were frequently anxiety dreams which usually centered around the experience of being bombed. In the course of analysis it became obvious that the relation to his mother was characterized by the oedipus complex. The analysis found further that the decisive idea behind the patient's feeling of smallness was unconscious notion that the size of his penis was inadequate and that, therefore, he was defenseless against his castrating father. In the course of his life the feeling of his smallness and the anxiety resulting from it had been transferred to all matters having to do with size.

This feeling found its strongest expression in the symptom of "cosmic fear." It might have been expected that this patient in whose conscious and unconscious life space played such a vital role, would have developed what Freud called the 'oceanic feeling,' and that from it he would have derived a sense of security. It was, however, not possible for this feeling to occur since it was based on an attitude of confidence and the ability to "surrender to the universe," as Freud put it. In its stead he developed what has been termed by Spengler a feeling of 'Weltangst' (world fear), i. e., a feeling of "infinite smallness as compared with immensity, an awe and a deep anxiety at the though of being lost in the sea of the unfathomable."

Both—world fear and oceanic feeling—have their foundation in a feeling of childhood helplessness and both play an integral part in the development of cultures. Both represent efforts to solve the problems arising from different cultures.

The patient, having grown up in a politically "conscious" era, attempted his flight into reality by surrendering to a political ideology. This action was a means of combatting anxiety as had been religion and the oceanic feeling for other individuals in other periods of culture. In contrast to the latter attitudes, the feeling of security the patient derived from his membership to the Party was based on a reality subject to frequent changes and to his conscious criticism. Therefore, when the belief in this reality failed, he was "left back in no man's land" and his security collapsed with it, thus promoting the onset of his neurosis. Lowenfeld adds that on his devotion to the movement depended the successful repression of the dreaded homosexual feelings which were at the bottom of his hatred for his father. Consequently, when his faith diminished, the resentment against his father rose again, provoking the sudden outbursts of rage mentioned above.

Lowenfeld cites this case in order to illustrate the profound difference between the neuroses encountered today and those of the past, for example, those described by Freud in his early works. He refers to Freud's description of the case of a young painter of the 17th century, who suffered violent attacks of hysteria. In his spells the painter imagined that he had concluded a pact with the devil and the devil would one day claim his soul. The hysteria was cured following the painter's "complete surrender to God" and his becoming a monk.

Lowenfeld sees the difference between this type of neurosis and that of the present day in the changed cultural background and hence also in the changed defense mechanisms of the patient. According to Freud, "the neurosis is a product of the great demands which civilization makes on man's instincts." In view of the fact that the mechanisms of defense and sublimation offered by an individual civilization change with it, Lowenfeld raises the question of whether "cultural development is not actually motivated by man's endless need for help in his struggle with his instincts." He emphasizes the importance of clarifying the relationship between culture and the chances for repression and sublimation this culture offers. As expressed by Freud, the success of an attempt at repression is determined by the extent to which it prevents feelings of pain or anxiety from arising.

While the immediate environment exercises considerable influence upon the success or failure of a repression, sublimation depends largely upon the influence of society.

The demands of the individual made by society differ with the social structures in different periods. Thus it was consid-

erably easier for the individual to adjust himself to the relatively stable reality that prevailed before the first world war than it is for him to cope with the unbalanced, changing reality of the present time. Before the first war, the aim of analysis was simply that of lifting repressions into consciousness; for the secure social system afforded a dependable support for the individual's adjustment. Our present insecure social structure denies the ego this suport and, in addition, constitutes a never-ending stimulant for the fantasies of the unconscious. In the case described, for example, the loss of protection through a political ideology caused a recurrence of the patient's fear of homosexuality. As Freud has pointed out: "Homosexuality, in its sublimated form, plays an important role in social relations and in the structure of society." In an unstable society the tendency of homosexual sublimations to collapse increase.

With the loss of his religious feelings, man has become increasingly dependent upon reality. This dependence, however, creates defense mechanisms which find their expression in social theories. Although these were originally created to aid in the understanding of reality, they have, in our time, become means of preventing the stimuli of reality from penetrating the unconscious. In the final analysis, these ideologies have become a "repudiatoin of reality" since they must be compulsively maintained even though they have lost their protective nature.

In conclusion, the author emphasizes that as long as man's struggle was principally directed against nature and the cosmos, religion was offering him a satisfactory solution for the prbolems arsiing from his instincts. In the present epoch, however, where the conflict lies with the civilization, solutions man himself has created are no longer effective. Thus, man tries to find his security within the realm of reality, through theories and ideologies. It is often difficult to penetrate the origin and function of these ideologies, "because they represent a normal attempt at a solution at the present stage of civilization, because they seem to be relatively rational, and above all, because analysts themselves participate in such ideologies" (p. 15). They frequently present, however, the most disguised form of the basic emotional conflicts of the unconscious and may form the cardinal resistances in analytical treatment.

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REMARKS ON THE COMMON PHOBIAS. OTTO FENICHEL, M. D. *The Psychoanalytic Quarterly*. Vol. XIII, No. 3, July 1944; pp. 313-326.

Freud, as cited by the author, has shown that psychoneuroses are the result of the conflict bteween regression into infantile sexual desires and the fears of the dangers unconsciously associated with them and that "neurotic symptoms are a compromise between the instinctual demands and the counterforces motivated by fears."

Fenichel points out that in most infantile phobic neuroses a situation which unconsciously constitutes an instinctual temptation evokes anxiety instead of excitement and is consequently avoided. In other types of phobias, anxiety is created by either aggressive impulses, memories of frustration, or an unconscious fear of punishment. In most cases it represents a combination of an unconscious temptation and fear of punishment.

Anxiety, common to most phobias, seems to fail in its original purpose to function as a "warning signal" against danger because in the danger situation it overwhelms the ego, causing it to lose control over itself. Consequently, repressed, accumulated emotions will be discharged and lead to what has been described by Freud as a "traumatic situation".

In an effort to avoid the danger created by the phobic situation, attempts are made to escape into a less dangerous situation. This may be achieved by either replacing one object of fear by another, less dangerous one, or by projecting the inner anxiety onto an external object or situation. Analysis shows that the choice of the substitute is dependent upon historical, somatic and instnictual factors.

One of the characteristics of phobic patients is regression into remobilized infantile helplessness and the consequent seeking of protection. This characteristic is especially evident in those cases of agoraphobia where the presence of a companion is demanded. As has been emphasized by Helene Deutsch, "the companion not only represents the protecting parent but additionally the unconsciously hated parent whose physical presence serves as a denial of unconscious destructive fantasies."

The author enumerates a few instances where the nature of the phobia was determined by some specific instinct, e. g.: exhibitionism and scoptophilia are avoided by agoraphobia; unconscious fantasies of erection by anxiety connected with heights.

Fenichel then proceeds to stress the importance of sensations of equilibrium as sources of infantile sexual excitement. Clinical experience has shown that in "equilibrial eroticism" erotic pleasure and anxiety are particularly closely connected with each other since it is the same sensory apparatus that registers equilibrium and some of the sensations caused by anxiety. Equilibrial phobias are the outcome of conflicts resulting from the "sexualization of infantile sensations of equilibrium". Moreover, infantile equilibrial eroticism may be remobilized in other types of phobias through the association of sexual excitement and anxiety.

The enjoyment people take in attending amusement parks is proof that this infantile equilibrial eroticism is retained in the adult. Most of the concessions in these parks are purported to evoke the emotions caused by stimulation of the sensory equilibrial apparatus. While some individuals openly enjoy the sexual pleasure derived, others may be afraid since their reminiscences of infantile eroticism only precipitate anxiety.

The sensations felt in the act of losing consciousness through either falling asleep or under narcosis represent "archaic types of ego feeling" which are regressively being experienced. Many of them are intimately connected with sensations of space and equilibrium. While, for example, some people find pleasure in being narcotized, most of them develop a phobia of having to experience a repetition of narcosis. Analysis has revealed that this type of phobia plays an important role in persons who have developed a fear of death. The author states "that a high percentage of death phobias are phobias of sensations of equilibrium and space", especially if they are connected with fears of falling, exploding, etc.

Fenichel agrees with Freud that the blocking of sexual desires causes anxiety and unpleasant vegetative reactions. These sensations are in part regressions into infantile equilibrial orientations. In analysis, impressions of rhythmical movements can only partly be explained as psychic reactions to an awareness of a sexual scene. In a wider sense, they are the outcome of the inability to discharge an overwhelming excitement, resulting in fearful equilibrial sensations.

The author concludes, therefore, that fear of falling asleep, of being anesthetized, or of having hay fever is caused by the subconscious fear of being overpowered by the distressing sensation of an equilibrial disturbance.

The analysis of claustrophobia reveals it as a typical example of a phobia because of the obvious projection of an inner excitement upon an external situation. As an example, the author cites the case of a patient with a compulsion to leap from the moving subway train. The initial pleasant sexual sensations caused by the movement of the train were soon replaced by the urge to escape from it as the intensity of the excitement became intolerable and threatened to release the traumatic situation. The ideas of losing equilibrium and falling, inherent in the desire to jump from the train, represent the vegetative sensations of the traumatic situation. Neurotic fear of falling may be traced to the same origin. To give in to the desire to jump in order to escape the unbearable anxiety caused by sexual excitement is at the same time the climax of this anxiety in the symbolic fulfillment of the forbidden wish.

According to Lewin a typical trait in claustrophobia is the presence of unconscious sexual desires which constitute an expression of infantile fantasies about intrauterine life. Clinically, claustrophobia is

facilitated by the following two physiological factors: (1) Restriction of physical freedom evokes anxiety; (2) Since anxiety is always associated with the feeling of being closed in, the actual condition of being closed in will naturally promote its appearance.

The fear of trains, boats or airplanes is based upon the knowledge that it is impossible to get out of the vehicle in case of an emergency, as long as it is in motion. Here again, the intensive need to discharge inner excitement caused by fearful sensations of equilibrium finds expression in the impulse to escape from the situation.

In seasickness the close connection between anxiety and equilibrial stimulation is a decisive factor. The author points to the possibility that there may be a stronger inclination toward seasickness in persons with "repressed sexualization of body movements in space". Repressed "equilibrium memories" may also be called forth through attacks of seasickness, causing neurotic reactions.

The patient suffering from claustrophobia is afraid of the collapse of his ego. His anxiety is caused by his inability to control the situation, e. g.: to leave a train or a room at will, or to escape the growing sexual excitement which leads to orgasm.

Specific sensations of fear connected with spaces find their expression in agoraphobia. One of the fundamental characteristics of fear is a sensation of "narrowness", expressing itself in a feeling of constriction in the chest. In an effort to protect himself against his inner anxiety, the patient projects his feelings of narrowness or broadness onto the street instead of onto his own body. (Broadness may substitute for narrowness through "representation by the opposite".) Some agoraphobics fear only narrow streets, some only open spaces, and some are afraid of both. Most of them dread a change in the width of the street. Many of these patients have to have the assurance of a possibility of escape from the fearful situation. This need represents their desire to escape from their own anxiety.

In some instances, phobias may be relieved through fulfillment of the phobic demand, e. g., avoidance of the external situation. In this case the patient has successfully projected his inner anxiety onto the external object. However, in other instances, the projection may fail—i.e., the anxiety reappears and other objects for projection have to be found anew every time. The success or failure of a projection is determined by the relationship between anxiety and instincts, this being dependent upon the individual background.

In some cases the projection of sensations of disequilibrium may be successful if it is to a certain degree supported by the environment. Patients suffering from inner anxiety and confusion may be relieved by external disorder. In the same way, the analysis of persons requiring outside stimulation in order to concentrate reveals an inner restlessness which they try to escape by placing themselves into an environment providing external noise. If, however, the external excitement exceeds a certain degree of intensity, it may suddenly become unbearable.

The author then points to certain normal reactions bearing a similarity to the inner mechanism of phobias. Just as the phobic personality attempts to project his inner anxiety upon external objects, the normal person will try to satisfy his narcissistic instincts in an identical manner. As has been shown by Hanns Sachs in a paper published in 1912, a person in contemplating a landscape will identify himself with it and project his feelings onto its objects. His becoming conscious of nature will not consist in the observation and registration of its objects but in the development of feelings created by the contemplation of them.

The phobias and the consciousness of nature are not the only instances in which sensations are projected onto external situations or objects. They are also evident in various types of ego regressions since the natural tendency to perceive one's environment as one would like it to be and as expression of one's own personality is a contradiction to the principle of reality.

In conclusion the author emphasizes that the fears of castration and of being abandoned are the deepest forms of infantile anxiety, forming the basis for the

development of the fear that the ego will be overwhelmed by its own anxiety. In an adult ego which has managed to achieve instinctual satisfaction and to cope with reality, instinctual temptation should evoke pleasant anticipation, not anxiety.

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"Self-Preservation and the Death Instinct." E. Simmel. *The Psychoanalytic Quarterly*, 13:160-185, 1944.

In a purely speculative article, Simmel elaborates on Freud's "dualistic" conception of instincts. He maintains that the "genital primacy" of the libido organization is preceded by a pregenital "gastro-intestinal primacy." The latter operates as an agent of libido and never ceases exerting its instinctual power. Between both primacies a conflict persists throughout life. In the course of maturing of the individual, the gastro-intestinal primacy becomes subordinated to the genital primacy. A "primitive object relationship" that is governed by hatred, then develops into a "civilized object relationship," governed by love. The "conflict of ambivalence" reflects the conflict existing between the two instinct primacies. Simmel claims that his theories go as far back as 1921 and 1923. They antedated Freud's publication on this subject, especially his book "Beyond the Pleasure Principle." Simmel from his theories expects to "shed new light not only on the genesis and dynamics of transference neuroses but also on narcissitic neuroses, psychoses and problems of psychosomatic medicine."

Simmel considers Freud's "death instinct" not as a destructive energy but as a manifestation of the instinct of self-preservation; the latter being a libidinal component of the ego. Freud's concept of libido appears enlarged to include the destructive energies within the instinct of self-preservation.

An instinct is a "borderline concept between the mental and the physical." It has a source, an object and an aim. The source of an instinct is a state of excitation within the body and its aim is to remove the excitation. The objective of the sexual instinct is that of providing organic pleasure to certain erogenous zones, chiefly mouth, anus and genitals. According to Freud, the pre-genital libido organization has destructive characteristics. Freud speaks of an "anal-sadistic organization of libido" and of an "oral-cannibalistic stage of libido." Thus destruction and libido are not irreconcilable opposites. Freud maintains that the infantile sexual instincts support themselves by the "instinct of self-preservation." It may be assumed that oral libido cannibalistic destructiveness and self-preservation are coordinated if not completely identical.

It was Freud's contention that the two forces governing life were hunger and love. Of the two, hunger as a function of the ego (in the service of self-preservation) was studied relatively late. His research on the ego deterioration in the narcissistic neuroses led him to state that the ego in all its conflicts can have no other tendency than "to defend itself." This means that the ego strives to keep its inner narcissistic libido equilibrium.

Simmel presents the idea that a general tendency exists to keep the libidinal tension within the ego at a certain even level beyond which pain (Unlust) is experienced. Anxiety is a specific phenomenon of a quantitative disturbance of this libido equilibrium. It functions as an alert for the ego, causing it to set in motion either the adequate instinctual discharges or the necessary psychic defenses. The perception of anxiety constitutes a danger situation for the ego. The ego may find itself helplessly exposed to the drives stemming from instinctual needs of the id. Fear of annihilation or death results from the perception that there is either an hostile object, stronger than the ego which opposes the release of tension, or that there is no friendly object available to bring about a release from tension which has become unbearable.

A normal ego is one that is entirely oblivious of itself while acting as a controlling agent or a damming-up basin for instinctual id energies. It has a perfect libidinal balance, and is entirely aware of

the outer object world. The normal ego depends on the effective operation of the superego. The superego aids the ego in appraising the libidinal intensity of instinctual needs and their chances of being satisfied by objects. The superego determines the capacity of the ego to perceive a situation of tension as a danger, and to react to it with the fear of death. If the ego perceives a condition of permanent and absolute helplessness because the object is out of reach, then the fear of death can be avoided by a new distribution of narcissistic libido, this time between ego and superego. The superego is able to take the place of the object and to bind the frustrated object libido. Like its parent protype, it can then provide the ego with a temporary instinct security, and thus act as a preventive against fear of death. Self-preservation is based on the ego's endeavor to keep itself free from anxiety. This fits in with Freud's idea that psychoneurotic and psychotic disturbances result from the difficulties that the ego encounters in warding off anxiety.

Freud supposed the existence of an instinct of self-destruction because self-destruction lies in the path of the ultimate tendency of all instincts to remove organic excitation, and to reinstate the earlier condition of "instinct repose." By self-destruction all organic excitation is removed and the inorganic condition, death, is reinstated.

The instinct of self-preservation fits well into the definition of an instinct. Its origin is the urge to devour; its organic source is the gastro-intestinal tract; its aim is to remove the stimulus of the gastro-intestinal tract; its object is food. While gratification of the sex instinct in removing the excitation of its organic source preserves the object, the gratification of self-preservation which removes the excitation of the gastro-intestinal zone destroys the object. There are valid reasons for assuming that all the variations of aggression and all destructive tendencies which develop in the course of life are derivatives of primitive demands of the gastro-intestinal zone.

Simmel then discusses the relations between self-preservation and libido. Before birth there is a complete instinct repose, which is identical with a perfect narcissistic equilibrium. Mentally it is expressed as unconsciousness. This condition is terminated by the act of birth, which represents a trauma. The narcissistic equilibrium is then restored by the first feeding. It is the satiation of the gastro-intestinal zone—the representative of the instinct of self-preservation—which brings about this complete instinct repose; the infant becomes unconscious again, i. e. falls asleep. This self-preservation from the very beginning of life, becomes associated with the tendency to preserve a complete instinct repose.

Proceeding from this speculation Simmel assumes that the earliest stage of libido development is not the oral but the gastro-intestinal organization. He points out that the infant is capable of regaining its general instinct repose only after the gastro-intestinal demands have been satisfied. Mouth and anus are orifices through which this sphere communicates with the outer world. Pleasure sensations experienced at those terminal zones have the character of pre-pleasure, the end-pleasure being that of digestion. The process of feeding can be considered as a symbolic cannibalism only if we take the function of the entire gastro-intestinal tract into consideration.These primordial experiences are the prototype of certain physical and mental defense reactions of the individual, which occur when the ego is faced with object frustrations and is in need of an instinct repose. The defense mechanisms of introjection and repression are psychic derivatives of the act of devouring which eliminates the object from conscious perception. Rage can be considered as a result of a disturbed narcissistic equilibrium caused by frustration. In infants it is caused by the physical sensation of hunger. Feeding (incorporation) restores the infant's narcissistic equilibrium and overcomes its rage. The wish to kill experienced by the frustrated individual is a repitition of this primordial experience.

Hate is an expression of gastro-intestinal demands, while love is an expression of genital demands. Rage and sexual excitation are primarily without an object. Both affects obtain their object relation through their emotional expressions. The German

word "*Hass*" is derived from *hatzen* which means "hunting," i. e. the pursuit of an animal for the purpose of killing and devouring (incorporating) it.

Freud stated that at the primitive oral-cannabilistic stage, the sex instincts rest upon the instincts of self-presrevation. It is evident that the libidinal destructive instinct of self-preservation is correlated with the demands of the gastro-intestinal tract. One can connect this instinct of self-preservation with Freud's concept of the death instinct, when one considers that both instincts aim toward the state of unconsciousness, as an expression of a complete instinct repose. This is the mental equivalent of physical death (the Nirvana principle).

Object destruction serves the purpose of self-preservaiton, that is, the preservation of the narcissistic equilibrium within the ego. In search of this state of unconsciousness and instinct repose, (Nirvana) the ego withdraws its libido from the outer world into its own libido reservoir. Contrary to the case of the infant, the satiated ego of the mature individual does not express its equilibrium as a complete unconsciousness; it is unaware of itself while functioning in accordance with the demands of reality. If, under pathological conditions, the instinct of self-preservation is released and is not restrained by the sex instinct, the individual will attempt to kill the whole surrounding world, in order to achieve his complete instinct repose. This seems to be the case with the schizophenic mass murderer, whose only link to the outer world may consist of his gastro-intestinal instinctual demands.

Simmel then proceeds to formulate his theories on psycho-neuroses and psychoses as far as the conflict of ambivalence is concerned. He states: "In every traumatic experience based on a frustration of the object love the ego tends to abandon its genital libido primacy in an exchange for a gastro-intestinal libido primacy."Through this regression the ego tries to revert to complete instinct repose as once experienced following the post-natal act of feeding. By means of the aggressive gastro-intestinal alimentary act we attempt to annul the trauma of birth and to re-establish a condition of release of all tensions. Here Simmel accepts Rank's theory of the significance of the trauma of birth, although he offers a different interpretation of it. He also maintains that the "cardinal trauma of castration" does not have to lose its significance, since it refers to the danger directed toward "just that organ zone which, under the genital primacy, mediates contact with the object."

In narcissistic neuroses and psychoses the ego abandons the genital primacy and gives into the gastro-intestinal primacy, the guarantor of a complete instinct repose. In transference neuroses the ego is arrested on the way to its ultimate aim of regression by the phallic and anal stages of libidinal object fixation. Manifestations of neuroses and psychoses reflect a defense of the ego against the dangerous consequences of its regressively awakened destructive (devouring) tendencies. The basic conflict of the ego in which it strives to "maintain itself" is the alternative of preserving the frustrating object, or of preserving itself (its narcissistic equilibrium. Regression of the ego proceeds from the transference neuroses via narcissistic neuroses towards the psychoses.

In transference neuroses the ego decides in favor of the object on whose existence it depends for the fulfillment of its demands of love and security. In the psychoses it tends to sacrifice the object in the interest of achieving complete instinct repose or of reestablishing the condition of primordial narcissism. In hysteria the individual restricts his unconscious devouring intentions to the genital organ of his object, the focus of his hatred, while preserving his love for the object as a whole. He desexualizes his object relationship either by the unconscious fantasy of having destroyed the object's genital or by defending himself against this wish. Globus hystericus represents the halting of the hated phallus on its way down to the gastro-intestinal tract.

The vaginal anaesthesia of the frigid woman is a means of defense against the devouring tendency of the vagina. The compulsion neurotic hates his object in its entirety and tends to devour it in toto. As a defense, his hands are blocked for they

have assumed the symbolic significance of the mouth. He preserves his object and discharges his hatred in his process of thinking.

In melancholics there exists a tendency of the ego to devour itself instead of the object. Simmel feels that the suicidal attempts of melancholics symbolizes actual wishes of self-devouring. In his self-torturing thinking the melancholic reveals a similar thought process as the ruminant thinking of the compulsion neurotic. The compulsion neurotic "acts out" a defense against his urge to devour his object, while the melancholic produces his self-torturing ideas as a defense against destroying (devouring) himself.

Simmel speaks in this connection of the "intestinalization" of thinking.He means that in the above cases the relationship between ego and superego appears "intestinalized." According to Freud, the severity of the superego results from aggressions of the ego. In terms of "intestinalization" it would mean that the superego has taken over the devouring tendencies of the ego and turned them against the introjected object within the ego. This is the basis of the "Gewissens-*bisse*," the gnawing of conscience.

The manic state of the narcissistic neuroses represents a fusion of the ego and the superego, a result of the devouring tendencies of the ego directed against the superego.

In schizophrenia the superego shares in regression of the ego and finally assumes the significance of the object-mother. The ego finds instinct repose by devouring the superego (mother), thus getting rid of remorse (aggression by superego). However, ego loses thereby a mediator between itself and object reality. Every external object becoming a mother object, the schizophrenic loses ability to test reality. The aggressiveness of the schizophrenic individual indicates the tendency to incorporate the external object in order to return to the condition of primordial narcissism, i. e. to complete instinct repose. The schizophrenic achieves his aim of complete narcissistic equilibrium in the condition of stupor. The modern treatment of shock therapy is but a short cut to this condition, which here is called coma. Through this coma the need to destroy the object of ambivalence becomes temporarily superfluous. The induced convulsions are a repetition of the uncoordinated movements of the infant in which it discharges is primordial objectless rage.

Simmel then attempts to apply his theory to the oedipus conflict in order to substantiate the validity of his theory of the psychoneuroses and psychoses from the point of view of object frustration. The author presents the view that this "second trauma" (the first being the trauma of birth) induces the ego to restore the disrupted narcissistic equilibrium after the pattern of the first trauma. This means: by giving in to the gastro-intestinal libido demands and by incorporating the object that brings complete instinct repose, mother. This process has been described by Freud as identification. Simmel states: "the instinct renunciation on the genital level is compensated for by an instinct gratification of the gastro-intestinal level." The highest achievement of the human mind—conscience—has its root in our desire to devour our fellow man. Simmel quotes Freud, saying: "Renunciation . . gives rise to conscience . . . " and: "It is only the aggression which is changed into guilt, by being supressed and made over to the superego."

In Simmel's nomenclature Freud's "aggressive instincts" appear as "devouring—destructive intestinal energies," derivatives from a "gastro-intestinal instinct primacy." Identification in this system is the result of the ego's regression to this gastro-intestinal primacy. It substitutes for and wards off physical incorporation. Simmel concludes his article quoting Freud, that within the ego and its defensive incorporations the same principle prevails that governs the organic world: "Devour or be Devoured."

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EIGHT PREREQUISITES FOR THE PSYCHOANALYTIC TREATMENT OF HOMOSEXUALITY. EDMUND BERGLER. *The Psychoanalytic Review* 31:253-286, July 1944.

The author's historical survey of the different concepts of investigators in this field clearly indicates the pessimism with which psychotherapists have viewed this malady. Few have had the temerity to suggest that a definite cure could be effected through psychoanalytic procedure or otherwise. Dr. Bergler nevertheless maintains that some desirable results can be effected in certain selected cases and has devoted his article to outlining some eight prerequisites for the treatment.

The objective point around which the selection of cases has been made is the breast complex by which is meant constellations arising from the sequence of weaning. These are more or less present in all homosexual cases but where they are particularly dominant with respect to psychic trauma, they offer opportunities for treatment not possbile in the other types. Bergler has outlined the pattern which is regularly obtained in the breast complex dominant type: (1) intensive hate against the mother; (2) "oral character traits," e.g. excessive desire to eat, suck, bite, drink, and their reactions and compensations—as part of a hypothetically oral instinctual constitution; (3) oedipal hatred against the father turns out to be quantitatively weaker; (4) interest in the breast in repressed; (5) intensified secondary narcissism; (6) intensified tendency toward identification.

Much space is devoted to the consideration of the Freudian concept of homosexuality with its emphasis on the oedipus situation and the syndrome of mother fixation, narcissism and castration fear. Out of this concept Freud has delineated three types of homosexuals: the first, who attempts to escape from the horror of incest by going from woman to man; the second, who identifies himself with the mother and then sets forth in the world to find himself. In this type masculinity may be retained through a homo-erotism. Where the masculinity is abandoned, the subject then seeks his substitute in some other person of the same sex, of course. The third Freudian types is the result of the patient's curbing his aggression against his brother or father and, therefore, a strong sense of frustration arises.

It is recognized that all men are capable of homosexual object selection and in certain phases in early life may be considered as normal behavior. However, the heterosexual individual may have much of this homosexuality repressed into his unconcsious and this plays a considerable part in his everyday psychological conduct. The fact, however, that this does not dominate his total behavior eliminates him from the homosexual class. Also, it must be recognized that homosexuals are capable of a good deal of heterosexual behavior. They may find strong attraction in women and, in turn, exercise considerable charm upon them. Heterosexual experiences are by no means uncommon in definitely homosexual subjects.

In the matter of therapeusis, however, Freud has found marked obstacles in that these types of patients are controlled by an archaic constitution and by primitive psychic mechanisms. "The importance of narcissistic object selection and the clinging to the erotic significance of the anal zone seem to be their most essential characteristics." The deep sense of guilt so prevalent in these cases is neutralized by the patient himself through unconscious self-provoked punishment. The patient welcomes failures to control his inversion through analytic procedures or otherwise because it gives him the "Go Ahead Signal" for permission to indulge in his perversion. He is like the neurotic—he does not really want to be cured of his troubles and he constantly seeks situations which are more or less falsely set up to cause him self-punishment and to give him the basis for feeling that he may indulge himself since the world proves to him that he obviously incurable.

Bergler attempts to meet this situation by making use of eight so-called prerequisites for treatment of certain selected homosexual cases, particularly those in which the oral-erotic component is dominant. He has listed these under sub-headings as follows:

(1) The inner guilt feeling capable of being made use of analytically. In other

words, the patient must give some degree of cooperation in actually wanting to be cured.

(2) Voluntary acceptance of treatment. The patient should not accept treatment on the basis of its giving him the excuse for indulging in his inversion.

(3) Not too extensive an amount of self-damaging tendencies. The oral-erotic dominantly controlled homosexuals are striving to get even with the world because they feel they have been deprived of certain privileges in their infancy. They, therefore, put themselves in the position of invoking situations which enable them to get revenge and at the same time to pity themselves masochistically. Fundamentally, they are masochistic in spite of their aggressive behavior. If these tendencies are not too deep, the patient is capable of a certain amount of readjustment through analytic procedures.

(4) Therapeutic preferability of homosexual reality to homosexual phantasy. The homosexual frequently is hostile in his attitude toward treatment for reasons mentioned above and he will react to the situation through phantasy instead of meeting the test of analysis on the basis of actual reality. The heart of this matter, of course, is the ability to obtain transference in such individuals. They are, in essense, repeating their pre-oedipal oral hate conflicts and, therefore, much of this is projected by them upon the analyst. Often they avoid an analyst who might correspond to their love object thereby enabling their hostility to act more effectively as a protective device against analysts of other types. This situation, of course, must not be too irradicable in order to secure proper transference.

(5) No real experience of complete psychic dependence on the mother. This type of homosexual is, of course, one of the most difficult to treat and Bergler suggests that these be rejected as being unfavorable therapeutically. He states that the "psychic elasticity" of this type of person is seemingly exhausted and there is no reserve upon which the analyst can work.

(6) No persistence of reasons for maintaining homosexuality as an aggressive weapon against the hated family. This is, in effect, a corollary of No. 5.

(7) No authoritative assertion of incurability. The analyst is cautioned by the author to avoid authoritative pessimistic judgments. Every attempt should be made by the analyst to assume an optimistic attitude because the whole question of the curability of homosexuality is still debatable. Furthermore definite damage can be done to the patient himself by attitudes on the part of the analyst which may be unjustifiable.

(8) The analyst's knowledge. The mere fact that the analyst is confronted by the homosexual's attitude to utilize him as a method of salving his feelings of guilt so that he may continue to indulge in his perversion from which he does not want to be cured, places the analyst in a peculiarly difficult situation. He must not only act with the utmost subtlety in his relation to the patient but must have his working tools capable of bringing about a swing of the patient's attitude into the proper channels. The author does not feel it is necessary to penetrate into the deepest levels in order to bring about readjustments but he must keep in mind that the psychic center in male homosexuality is the pre-oedipal mother attachment and the breast complex. Contrary to many of the situations among neurotics, the oedipal situation is of secondary importance in these homosexual patients. Reference, of course, is made to acceptable types of homosexuals and not in those in which the mother-hatred is dominant.

The importance of this article is that Dr. Bergler has injected a note of optimism into a field which has been almost universally accepted among psychaitrists as barren soil for therapeutic procedures. He has gone a step farther in outlining prerequisites necessary for a successful approach to certain types of homosexuals. He has evaluated the various concepts of homosexuality by investigators, has given full consideration to the all-important Freudian concepts and out of these has drawn conclusions that the situation is far from being a hopeless one.

V. C. B.

ON GENUINE EPILEPSY. RALPH R. GREENSON. *Psychoanalytic Quarterly*. 13:139-159. No. 2. 1944.

Greenson briefly reviews current opinions on the psychological structure of the epileptic reaction, among them Freud's (psychic tensions are discharged somatically in the epileptic attack); Ferenczi's (epilepsy represents a fixation on a narcissistic level); Reich's (the epileptic convulsion constitutes an extragenital orgasm); Schilder's (the epileptic attack is similar to the phenomena of birth); Simmel's (epilepsy is self-induced shock therapy); and Kardiner's (the epileptic attack may be traced to a shrinking of the ego). Greenson then emphasizes that "there is an organic predisposition to epilepsy which can become manifest through psychogenic factors" and also that "there seems to be a psychological predisposition to genuine epilepsy, namely strong anal sadistic trends". Following that he describes the case of a twenty-year old boy with typical *grand mal* seizures.

The patient was fairly good-looking, well built, rather shy and very cooperative. He was the third youngest of thirteen children and got along with all the family except a chronically alcoholic brother and his father. He frankly admitted that he had an intense hatred for his father whom he considered a weakling and whom he made responsible for his own weaknesses. In the boy's childhood, this resentment had manifested itself in violent outbursts of temper and later in great fear of the father.

The illness had been of six months duration before the patient submitted to treatment. He was given phenobarbital and dilantin for one year without any success. At the time he was examined by the author he was having about one *grand mal* attack a day with an occasional *petit mal*.

In the early stages of his psychiatric treatment the patient was hypnotized twice and both times given the command to imagine that he had a spell. Both times the hypnosis resulted in the recollection of a childhood incident which he associated with masturbation. He admitted that masturbation had always been a great problem for him and that it had caused him strong feelings of shame and guilt. After the second session, during which he had a seizure and consequently felt that his "spells were like masturbation", the patient went without an attack for four days for the first time in months. Thereupon psychoanalytical treatment was initiated. Because of the interference by the patient's parents the analysis had to be interrupted after seven months.

During the analytical sessions the patient had many seizures all of which, strangely enough, ended before the hour was up. They were nearly always preceded by an aura during which the patient felt an electric tingling all over his body or a sinking sensation in the pit of his stomach. The aura was usually followed by deafness, then unconsciousness. The deafness sometimes persisted for 15-20 minutes after the attack. It was observed that the seizures were mostly precipitated by sudden loud noises. Thus the patient's first attack had occurred when a dog had suddenly barked at him. (Analysis revelalater that dogs had played an important role in the childhood masturbation experience which the boy had mentioned during his hypnosis). Generally all sudden stimuli as well as references to the patient's sexual activities, emotional affects and the recounting of his dreams would bring about convulsions or the sensations experienced in the aura.

There were strong resistances to the analysis, particularly in the beginning. The repressing factors were found to be chiefly an unwillingness of the patient to part with his secrets, and feelings of shame and guilt. These were directed against scoptophilic and exhibitionistic impulses which could be traced to overstimulation due to the cramped conditions in the boy's home during his childhood. The relationship to his father was also an important factor of resistance. Part of his resentment was due to the fact that the boy felt that the father who punished him for his sexual activities, i. e. masturbation, was himself "oversexed." On the other hand, he envied the father's "virility" and interpreted his inability to deal with his own masturbation as weakness. He had developed an oedipus complex with regard to his mother

whom he considered the victim of his father's excessive sexuality. Homosexual and incestuous trends were evident in the patient's dreams and fantasies and he also admitted that it had given him pleasure to exercise cruelty toward a younger brother and to torture animals.

In the later phases of analysis, fantasies of castration appeared which were interpreted as "punishment for his forbidden sadistic sexual wishes" (p. 152). At this point it seemed that the patient was beginning to gain some insight and the number of his seizures was somewhat diminished.

The next phase was characterized by distorted castration fantasies and convulsions during every analytical session. Finally the patient developed a strong fear of spells during the analytical sessions and tried to avoid them by long silences.

The analysis revealed the following trends: strong aggressive and criminal drives; passive-homosexual tendencies; exhibitionistic and scoptophilic impulses. They were partly reaction-formations, partly direct instinctual manifestations. "The tendency to accumulate tensions instead of discharging small quantities and the blocking of vasomotor outlets with shift to the central nervous system were striking. The aura was found to be an anxiety equivalent as well as an orgasm derivative. In the seizures, fantasies appeared which contained a castration idea and an allusion to incestuous wishes, as well as a repetition of his hypnosis experience. In the preconvulsive and postconvulsive state murderous, sadistic and destructive drives were occasionally fantasies. The first attack was precipitated by a stimulus which was associatively connected with infantile repressed material. Later the seizures were precipitated by similar stimuli as well as by situations that increased the internal tensions—either anxiety, sexual excitement, or rage." (p. 157).

Greenson then proceeds to say that "all psychological stimuli which increase the internal tensions, especially those which touch on a repressed infantile nucleus, may precipitate the attack. The attack itself is a trauma and is reacted to with the phobic mechanisms we see in the hysterias. This gives a secondary phobic superstructure to the clinical picture. The attack may also be felt as a punishment and be submitted to in a masochistic way. Finally the seizures may permit the discharge of hitherto repressed fantasies." (pp. 158-159).

The author is of the opinion that "this case belongs in the category of the pregenital conversion hysterias, or organ neuroses. We might formulate that an unconscious constant need to discharge aggression stimulates certain cortical areas in the brain, which are predestined as an archaic discharge center. Where this center is hereditarily predisposed to dysfunction it may become the most accessible vehicle for the expression of the unconscious needs" (p. 159).

Many of Greenson's views reflect ideas on the psychodynamics of epilepsy which Stekel expounded as far back as 1911.* The reviewer wonders why Greenson in discussing the psychological findings in epilepsy did not quote Stekel who was one of the pioneers in this field.

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* "Die psychische Behandlung der Epilepsie" (Psychotherapy of Epilepsy) Zentralbl. f. Psychoanaly., I, 5; Bergman, Wiesbaden, 1911.

See also "Der epileptische Symptomenkomplex und seine Behandlung" (The Epileptic Syndrome and Its Treatment), Fortschr. d. Sex. Wiss. u. Psychoanal., Vol. 1, Denticke, Vienna, 1924.

B - Neuropsychiatry

AMNESIA, REAL AND FEIGNED. WILLIAM G. LENNOX, M. D., *The American Journal of Psychiatry*. 99:732-743, No. 5, March 143.

This paper, one of a series entitled: Scientific Proof and Relations of Law and Medicine, is an effort to both expose and exonerate those who seek to escape the law by pleading irresponsibility for their actions.

According to Lennox there are three main types of amnesia: (A) *pathological,* (B) *psychological and* (C) *feigned.*

(A) The term "pathological" may be applied to cases in which the amnesia is caused by or associated with an abnormal condition of the brain which may be either "imposed" or "inherent." A person suffering from this type of amnesia is sick and not responsible for his actions. He should be treated in hospitals, not in prisons.

Temporary amnesia may be caused by acquired pathological conditions of the brain. These may be produced either by injuries to the head, or by loss or impairment of consciousness for example from toxemia, asphyxia, syncope, overdose of narcotic drugs, insulin, etc. The most common cause for amnesia, as far as the law is concerned, is alcoholic intoxication.

Amnesia due to inherent brain disorders is most frequently found in persons suffering from epileptic attacks. Electroencephalographic studies in epilepsy show a specific irregularity of the electrical pattern. "The brain wave pattern is an hereditary trait and abnormal waves, if not caused by some acquired brain injury, are an inherent disturbance in the normal functioning of the brain, transmitted through one or both parents."

Amnesia is common to all three main types of epilepsy. Grand mal attacks are often accompanied or overlaid by amnesia. There the character of the convulsions and possible injuries help in the diagnosis. The psychomotor epilepsy has often been confused with petit mal but can readily be distinguished by its different brain wave pattern. The manifestations of the psychomotor attack show considerable variety as to their appearance and severity. While in the majority of cases the patient is in a dazed and helpless state, performing a series of automatic movements or actions, there have also been instances when complicated acts were carried out with intelligence and skill. In this connection Lennox quotes Hughlings Jackson's case of a physician who suffered from periods of amnesia. "He was about to examine a patient's chest when he felt the aura of an attack. 'I remember taking out my stethoscope and turning away a little to avoid conversation. The next thing I recollect is that I was sitting at a writing-table in the same room, speaking to another person, and as my consciousness became more complete, I recollected my patient, but saw he was not in the room.' Later he found the patient in bed and the diagnosis which he, the doctor, had written ("pneumonia of the left base") on re-examination was found to be correct."

Generally, attacks of epileptic amnesia have fairly definite limits with the person usually being able to remember what happened up to the point when he lost consciousness. The end of the amnesia is mostly not so well defined. It may last well beyond the actual seizure even though the patient may give the impression of having regained his normal state.

The amnesia caused by psychomotor epilepsy is permanent and usually complete although in some cases the persons have had a hazy recollection of the events that occurred during the attack. The epileptic amnesia embraces only the period of the seizure and is not retrograde. The electroencephalogram offers satisfactory proof of the genuine nature of the amnesia caused by psychomotor epilepsy since the brain wave record shows typical abnormalities during the period of amnesia. A further indication of the importance of the electroencephalographic test is the fact that 85% of all epileptic cases show abnormal records even in the intervals between seizures.

Psychomotor epilepsy occurs relatively infrequent, and only in very rare instances will an act of violence be committed during a psychomotor attack.

Lennox points out that Maudsley was among the first to emphasize that occasionally sudden attacks of rage may be the only manifestation of epilepsy. Maudsley urges careful investigation with regard to a previous epilepsy of persons whose crimes were committed in some extraordinary manner and apparently without premeditation or motive.

It appears that suicide is the "crime" most frequently committed by epileptics, the rate, according to Prudhomme, exceeding several times that of the normal population.

The author notes that the incidence of epilepsy among various prison populations is relatively high (according to Baker it is 6.8% in the Broadmoor Criminal Lunatic Asylum in England). On the other hand he agrees with Hughlings Jackson, Gowers and Muskens that in private practice acts of violence committed during epileptic seizures are practically non-existent. This finding is supported by reports from various state colonies for epileptics. However, acts of potential danger performed during psychomotor seizures were reported in many instances. Thus, Hughlings Jackson tells of a boy who opened a pocket knife holding it by the blade; of a man who during an attack unbuttoned his trousers; and of a woman who began to cut bread but instead slashed her arm. Gowers mentions a man who struck a bystander, another who put articles in his pocket, and a woman who threw her child downstairs.

In reviewing the case histories of approximately 5000 private and clinic patients Lennox et. al. arrived at the conclusion that while only in extremely rare instances did the patient's actions during the period of epileptic amnesia lead to legal consequences, it happened quite frequently that the patient fell victim to injuries or accidents while he was unconscious.

As to the question why some epileptics commit crimes during their seizures and others not, and why the same patient may have a serious of harmless attacks and then suddenly one of great destructivenses, Lennox offers the following explanations:

(1) Every type of seizure originates in a different area of the brain. Experiments with cats show that stimulation of a certain portion of the cortex produces an attack of rage and it may be that a similar reaction takes place in human epileptics during the seizure.

(2) Actions performed by the patient shortly before the attack may greatly influence his behavior during the psychomotor seizure. Baker describes the case of a woman who had an attack while she was slicing bread and during the spell cut off her child's hand.

(3) An act of violence may be the result of a psychosis present in an epileptic patient. The violence may take the form of a psycho-motor attack with its usual manifestations.

(4) Volence may result from attempts to forcibly restrain a person in a state of automatism. It may also be caused through the restraint imposed by sedatives. As an illustration, Lennox describes the case of a young woman of excellent disposition who had suffered a great number of petit mal but never psychomotor attacks and who was given large doses of luminal. As a consequence, she "became irrational, walked onto the street in winter time in her night clothes, carrying a box of candy for her doctor. When found and brought into her room, she fought with and injured her sister and for several days was surly, negativistic and belligerent towards doctors and friends." Later her recollection of the events was hazy and confused. She never had another attack of this type.

(5) Frequently, alcohol may precipitate a seizure. Persons who become violent under the influence of drink are even more dangerous when they are epileptics with a bad disposition or when they have previously suffered from psychomotor attacks.

(B) In "psychological" amnesia the condition of the brain cells is not affected as in the previous group. There is, however, a deviation from the normal in the person's psychological processes or reactions. He is usually described as suffering from a psychoneurosis or hysteria and his amnesia is as real as one originating, for example, from a head injury.

Psychological amnesia is generally caused by the inability of the patient to face a certain situation and by his effort to escape it by way or forgetfulness. In contrast to pathological amnesia, this type can easily be reversed by solving the dilemma at its root. Events, repressed into the subconscious sphere, will slowly emerge again and thus the memory will gradually be restored. In contrast to the epileptic amnesia which embraces only the period of the attack, the hysterical form usually covers a much longer time, sometimes the whole past life. The victim of a hysterical amnesia has been acting normally before the onset of the amnesia, and, "since the psychological act of forgetting occupies only a moment of time" also behaves normally during the period of amnesia. While the epileptic worries over past amnesia the psychoneurotic appears rather unconcerned over his loss of memory.

According to Hopwood and Snell, crimes followed by amnesia occur often in states of depression while they are rare in manic states and schizophrenia. Emotional crimes are generally easier recalled but the crime itself is usually remembered last. Recovery may be speeded through the aid of association tests, questioning and the analysis of the person's dreams.

The diagnosis of psychological amnesia may be difficult. A normal electroencephalogram, previous similar episodes, a history of psychoneurosis or hysteria and some other factors of the patient's past may support the diagnosis.

(C) A third type of amnesia is the "feigned" form. In these rare cases amnesia is simulated with the aim to prove irresponsibility and thus to escape punishment or some other unpleasant situation. The diagnosis can be made by excluding the symptoms of epileptic and psychological amnesia.

The different forms of amnesia may be present simultaneously in on patient; a case like that may be classified as a "mixed type."

Two recent discoveries will be of great help in the differentiation of the pathological form from the other forms of amnesia: electroencephalography and the drug phenytoin sodium. While electroencephalography aids by the nature of its technical recording of brain waves, the therapeutic value of phenytoin sodium in psychomotor epilepsy may prove to be of great diagnostic importance. The beneficial effect of this drug in a case of violence with amnesia will assist in the recognition of the condition and may exonerate the defendant. As to electroencephalography, certain limitations in its diagnostic value have to be taken into consideration. Abnormal brain wave records in the imposed amnesia of syncope, hypoglycemia, delirium and drug addiction can be found only during the period of amnesia. In the case of a brain injury they may persist for a long time, even years. It appears likely that in cases where amnesia is inherent the brain waves were always abnormal but are worse during the actual attack or the period of amnesia.

Electroencephalographic evidence cannot be regarded as conclusive since about 15% of epileptics have normal brain wave records while about 15% of normal persons show an abnormal pattern. Part of the latter group are relatives of epileptics. Moreover, it was found that 30% of a mixed prison population had abnormal electroencephalograms without being epileptics in a clinical sense (Gibbs, Bloomberg and Bogchi). Hill and Watterson (England) noted that 65% of aggressive psychopaths show abnormal brain wave records in comparison to half that percentage among the inadequate psychopaths.

Lennox suggests that criminals whose crimes have apparently been committed without "motive, premeditation, preparation, memory of the event and attempt to avoid arrest" be made subject "to intensified medical research and therapy in order to determine if drugs, effective for the control of psychomotor epilepsy, might save society the burden of their prison support." He further notes that even criminals who at the time they committed the crime suffered from neither amnesia nor a seizure may have grossly abnormal electroencaphalograms which would suggest some form of brain pathology.

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MEASURES OF SUSCEPTIBILITY TO NERVOUS BREAKDOWN. W. HORSLEY GANTT, M. D., *The American Journal of Psychiatry*. 99: 839-849, No. 6, May 1943.

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The author emphasizes the inadequacy of present methods of determining an individual's susceptibility to nervous breakdowns and points out that a method is needed which is "1) *objective* (therefore varying minimally with the examiner); 2) capable of being *recorded* (and thus available for comparison by day to day and from one individual to another); 3) *quantitative* to a certain degree; 4) concerned with *significant* items, having a high correlation with the characteristics of the patient that are essential, viz., those that determine his susceptibility to break under stress."

The method proposed by Gantt would 1) determine each individual's reactions under normal conditison; 2) gradually increase the difficulty of the situation; 3) establish the point at which the individual's reactions become abnormal.

The author credits Pavlov with having been the originator of the method of determining psychic phenomena by their somatic reactions. To this end, Pavlov observed changes in the salivary secretion and regarded the conditioned reflex as the measure for this somatic reaction.

Gantt and his colleagues demonstrated that both the conditioned reflex (cr) and the unconditional reflex (UR) remained fairly constant under strict standard conditions. It was found that the UR increases in direct linear proportion to the stimulus, irrespective of whether additional stimulus was added to a basic large or small stimulus, while the cr with progressively increasing stimulation at first increased but then stopped or continued to increase only at a very slow rate.

Experiments with dogs proved that there exists a quantitative relationship between the cardiac cr and the stimulus applied. Each individual shows a typical change in his heart rate in accordance with the type and quantity of excitation and inhibition. The author prefers the use of the cardiac cr to Pavlov's method because of its greater sensitivity and reliability (as shown by Tunick in his laboratory). He notes, for example, that the cardiac cr persists in dogs longer than the motor or secretory reflexes, after a long period of rest. The heart rate changes to practically the same dgeree during the cr and UR and less during inhibition. It is justified to regard this change in heart rate as a measure of the cr or the emotional tension respectively since in the satiated dog the cardiac cr *and* the salivary secretion are absent.

The threshold at which a breakdown may occur was found to be dependent upon certain physiological and pathological conditions. Thus it was first observed in 1930 that dogs are particularly susceptible during the postpartum period. One of the dogs showed definite lowering of the salivary cr in the first few days after the arrival of the puppies while another dog did not show any variation in the motor crs although some change was observed in his cardiac crs.

Proof that natural emotional shocks produce different changes in individuals of different temperament was established by recording the crs of three dogs after they had escaped from the paddocks and had had to be brought back by force. While the stable dog was slightly affected and subdued for only one day, the labile and the inhibitory dogs showed severe reactions and were depressed for three day and a week, respectively. The author stresses the fact that it was only by having previously established a normal base line that the pathological changes in the crs could be detected—"for the criterion is a change from the normal for that particular individual."

Considerable variation in the crs of differently disposed indivdiuals was also noted when artificial strain was imposed. For example, the stable individual quickly differentiated between excitatory inhibitory metronoms, responding properly to each; on the other hand, the over-sensitive dog exhibited considerable restlessness in his behavior and reacted continually to both the excitatory and inhibitory stimuli. Parallel changes could also be observed when testing the respiratory and cardiac crs. With regard to the latter, the stable dog showed a decrease in his normal heart rate with a more difficult differentiation, while the heart rate of the sensitive dog

was almost doubled with the difficult differentiation. It is important to note that the difference between the stable and the labile dog could not be detected by mere external observation and that it was impossible to predict how either one would react.

The salivary secretion is dependent upon the function of the autonomic nervous system. The salivary cr is so sensitive that of all the present methods it may be the only one to indicate deviations from the normal behavior. Furthermore, the autonomic cr may continue after a long period of time when all the other crs, artificially produced ones as well as those connected with such strong stimuli as the sight and smell of food, have disappeared. As an example, Gantt relates the case of a very labile dog in whom ten years after a conflict the autonomic crs were still abolished when he was returned to the old environment. On the other hand, his unconditional salivary reflexes were still present. In contrast, a stable dog subjected to the same conflict showed only a slight deviation from the ordinary in his behavior and his salivary crs and went back to normal a few days after the experiment.

Another important evidence of pathology is the degree of fluctuation of the crs as well as of other functions. This was determined by the changes in the curves of the blood sugar of three dogs who had repeated glucose test meals. It was found that the dog with the most labile temperament had the greatest fluctuations, the most stable one had the least, and the third dog whose susceptibility was intermediate between the two showed blood sugar fluctuations that were intermediate between the fluctuations produced by the other dogs.

In another effort to prove that "not the absolute activity but the *change* in this activity is the important factor of susceptibility," the author cites the case of two dogs both of whom were suffering from severe neurotic disturbances. While the daily running activity of one of them showed great fluctuations after he became neurotic, the other one turned almost completely inadequate and was evidently depressed every time he was brought into the laboratory.

Although as far as humans are concerned no definite technique has been worked out, experiments have proven that a method simliar to the one above may be used successfully. A conditioned reflex test worked out by Gantt (Arch. Neurol. Psychia., 40:79-85, July 1938; South. Med. J., 31:12, 1219-1225, Dec. 1938) creates a problem the difficulty of which is gradually increased. Records of a normal person showed that he responded to the test regularly and undisturbed, his crs being in accordance with the stimuli applied. On the other hand, a hyper-active schizophrenic reacted at first with a severe disturbance in respiration. Later, as he lost his anxiety and was able to make the differentiation his breathing became more regular and he reacted appropriately to the conditional stimuli. Another experiment, involving a catatonic, proved that the patient's ability to differentiate and to form the adequate crs was dependent upon his clinical condition—i. e., when he was alert and able to talk his cr records were closer to normal.

Finally the author emphasizes that the test is of much smaller significance in humans than in animals; that this method constitutes a test of function indicating hte susceptibility of the individual to an acute temporary disturbance. Thus it has a direct relation to the stability of the nervous system and may consequently be of considerable value to psychiatry.

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STUTTERING: A CLINICAL STUDY. J. LOUISE DESPERT. *American Journal of Orthopsychiatry*. 13:517-525, July 1943.

This paper presents preliminary findings of an intensive study of 15 stuttering children and their case histories at the Out-Patient Department of the Payne Whitney Psychiatric Clinic. The patients included nine boys and six girls who were treated by several staff physicians and followed up for periods of time varying between three months and three years. A careful investigation was made of etiological factors in the family backgrounds and antecedents of the stutterers.

The interpretations and conclusions

drawn from the data were limited by the fact that information concerning the psychotic and psychoneurotic symptoms in the family histories of the subjects was not completely reliable as given by the average informant. In addition, parents as informants frequently tended to place too much emphasis on certain aspects of actual behavior because they represented an annoyance to them. However, these possible sources of error exist in some degree in most indirect psychiatric studies.

Information concerning the presence of stuttering in the direct or collateral lines in five cases indicated that stuttering was present in the father in three cases, the mother in one, and the maternal uncle in another. Six cases had at least on grandparent who was conspicuously unstable, neurotic or maladjusted. Two cases of psychotic episodes in a parent were found and psychoneurotic factors were present in the direct line of antecedents in at least one parent in all the cases and in both parents in six cases. The predominant neurotic characteristic as regards the mother was anxiety while in the father it varied from instability to paranoid thinking.

A significant finding was the fact that the symptomatic oral orientation in the child was determined by the mother's anxiety. The mother had usually been especially anxious about activities related to the oral region during the child's early years, manifested about eating and the fear of consequences attending the failure to eat. Also, the stutterers had a relatively low birth weight which the author attributes to the maternal rejection factor or poor psychological adaption of the mother to the expected baby.

The mother's own personality characteristics were important to note. In 13 cases she was a domineering individual, generally overanxious; 11 cases showed positive evidence of the mother's ambivalence; and in six cases the mother showed compulsive characteristics. The children as a group showed a marked dependence on the mother, a characteristic related to the mother's own anxiety.

The attitude of the father toward the child did not appear to have a conspicuous significance in the genesis of the speech defect. The child's attitude toward the father did nevertheless reveal some interesting facts. For example, anxiety, fear, and hostility toward the father were reported in seven children whereas in all others, except for some temporary hostility or anger, the relationship was habitually affectionate.

The duration of breast feeding bore no relation to the development of speech defect but early feeding difficulties were present in 12 cases while in all but two cases feeding difficulties were reported at some time. In the bowel training of the stutterers the mothers were found to have stressed regular bowel movements and the use of enemas and laxatives, or spanking, or other means of coercion.

Other data presented in this paper concerns such important factors as bladder control, masturbation, onset of speech, handedness, coincidence of trauma and speech pathology, physical development and status, motor development and status, aggressiveness, compulsive characteristics, neurotic traits, dreams, fantasy life, and attitudes.

The total analysis of the 15 child stutterers showed that not enough emphasis has been placed on the oral level of functioning and the close interrelation of chewing and speaking. This relation was often brought out spontaneously by the children themselves when they expressed the difficulty of bringing out the words. The author calls attention to the fact that the same structures are used to incorporate and take in food as well as to articulate and pour out words. Also, the conclusion is reached by Dr. Despert that the speech disorder is only one aspect of the neurotic personality of the patient and that there are always other neurotic traits present. This last point clearly contradicts the present general conception of the psychodynamics and treatment of stuttering and points to the need of revising this prevalen conception as well as the current theropeutic approaches especially since the number of stutterers in the United States is 1,300,000 and the majority of these cases are being treated by means of speech techniques which involve only the speaking organs and function.

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PSYCHOPATHOLOGY OF STUTTERING. J. LOUISE DESPERT, M. D., *American Journal of Psychiatry*, 99:881-885, No. 6, May 1943.

The author notes that stuttering has failed to be recognized as a psychiatric problem and supports this view with figures showing that a very large number of speech defect is rarely a purely tonic or clinics while the number of those admitted to psychiatric clinics is relatively small.

The speech defect caused by stuttering may be either tonic or clonic, the tonic disturbance being in the nature of "blocks;" while the clonic is characterized by the repetition of speech sounds. The speceh defect is rarely a purely tonic or clonic one but is usually predominantly one or the other. It is frequently accompanied by involuntary movements of the face or body and occasionally also by respiratory and vasomotor disturbances.

The peripheral structures and functions related to the act of speech are the following: 1) respiration; 2) larynx; 3) the tongue, soft palate, uvula, lips, and lower jaw. The lips and jaw are parts of the upper digestive tract and may be voluntarily controlled. In this paper the relation between eating and speaking is stressed as an important factor in the etiology of stuttering.

The author quotes the following theories regarding the development of this speech defect: heredity (J. S. Greene); disturbance in dominance of cortical control (Orton and Travis; endocrine disturbance (Da Costa, Ferreira, Starr, Stratton); inadequacy of conditioned response (C. S. Bluemel); disturbance in the function of linguistic realization (Pichon and Borel–Maisonny); and the psychoanalytical conception which, as pointed out by Coriat, regards stuttering as the result of the persistence of the primitive pleasure of sucking.

In a clinical study of 15 stuttering children, the author observed that with the majority the speech defect had begun between the ages of two to three years, i. e. the age when hte children develop such habits as feeding themselves, hand preference, walking, forming sentences, controling elimination, etc. Anxiety, motor restlessness and fine motor disturbances were evident in all cases. One of the most important determining factors in the development of stuttering appeared to be the mothers' neurotic attitude during the children's early eating-speaking phase. The chlidren were overdependent upon their mothers, most of who were "disciplinarians and perfectionists." Anxiety dreams and hostility were frequently present. In a previous study of normal children the author had found that anxiety was closely connected with "transitory speech deviations similar to stuttering."

The author then proceeds to describe in detail the case of a little girl who was first examined at the age of three years and three mnoths–four months after she had developed a predominantly tonic speech disorder. The family had unsuccessfully tried to deal with the disorder by whispering and supplying the words which they thought the child was trying to say. The patient was the second of two children, her brother being nineteen months older than she. The father was right-handed, with clear speech; a serious, sensitive, rather anxious man. The mother, also right-handed, was tense and subject to frequent changes of mood. After the little girl's birth she had suffered an eighteen months' depression during which time she gave all her attention to the older child, neglecting the baby.

The case history revealed that at the age of two years the patient had suddenly started to develop poor eating habits. There was lack of appetite, she dawdled, hoarded her food, messed it up and threw it on the floor. The mother felt that "the child has got to eat or she will starve" and the meals developed into a constant fight between mother and child. The child appeared shy and inhibited and afraid of people, particularly her father and her brother for whom she was "an easy victim." She had always been left-handed but was always "changed." Otherwise there were no deviations from the normal in the child's development.

When she was first seen, the patient was very anxious for her mother to remain and when she left went to look for her several times. In the playroom her activity consisted chiefly in cooking things for the physician while she remarked that she did

not like to eat. She demonstrated a great deal of oral activity, such as chewing toys and loudly blowing a trumpet. She was extremely conscientious about putting each toy back into its proper place, and very polite. Her speech defect was severe, accompanied by spastic movements of the oral and facial muscles and she sometimes repeated a syllable two or three times. The block generally lasted from five to twenty seconds but on one occasion the spasm was found to last 45 seconds. The physician did not comment on her speech nor did she show any curiosity with regard to what the child wanted to express. The same predominance of oral activity was evident in approximately the next six sessions. An almost constant tremor of the child's oral muscles, somewhat similar to chewing motions, was observed and there also were oral components in her play fantasies.

The mother was advised to relax the rigidity of her training; to ignore the speech disturbance; to offer the child more freedom and outlets for her need for oral activity (chewing gum, whistles, and such), and to arrange for a special space where the child could carry on "messy activities." Gradually the child became less anxious, more self-assertive, and developed an aggressiveness which was also evident in her dreams. In her play fantasies she identified herself closely with her brother and expressed the desire to be a boy. At the same time the nature of her speech defect changed in that it took on a predominantly clonic quality. After three months of intensive treatment during which she was given the opportunity to abreact her growing aggressiveness in the play sessions, the child had lost her bad eating habits, was happy, free and her speech had become clear.

In the course of the treatment the mother was interviewed frequently and was able to gain some insight into her own conflicts with regard to her children and her marriage. She was encouraged to exploit her talents which she felt had been frustrated through the marriage and as a consequence her tension diminished considerably.

In conclusion, the author again emphasizes the importance of the mother-child relationship during the child's early eating-speaking phase, and the influence the mother's psychoneurosis may have on the child's speech development, for example through interference with hand preference. Anxiety is regarded as a basic and primary factor in the development of stuttering, not as a consequence. In older children and adults it may, however, develop as a secondary manifestation to the speech defect. The importance of studying the personality development of stutterers is also stressed.

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NOTES ON THE PROBLEMS OF SUICIDE AND ESCAPE. LAWRENCE F. WOOLLEY, M.D., AND ARNOLD H. EICHERT, M. D., *The American Journal of Psychiatry*, 98-110-118, No. 1, July 1941.

The authors emphasize that the problems of suicide and escape from institutions are closely related with one another and that they have a common psychological basis. They point out that most of the publications on this subject concern themselves almost exclusively with the motives and causes for these actions while only very few suggest practical means of preventing them.

This study was inspired by the observation made at the Sheppard and Enoch Pratt Hospital that in the course of nine years (from 1930 to 1938, inclusive) the incidence of successful suicides and escapes as well as of attempts at such decreased appreciably (from four in 1930 and five in 1931 to none in 1937 and one in 1938), despite an increase in the number of patients from 222 in 1930 to 280 in 1938. The authors compare this steady downward trend in their institution with the general trend in the United States within the same time and find that, while there is evidence of a general decline in suicide, there is still a remarkable difference in the proportion, in favor of the Hospital. Noting the considerable discrepancy in the frequency of suicide at their hospital on the one hand and among the general pop-

ulation and the New York State hospitals on the other, the authors draw the conclusion that the incidence of suicides at hospitals is independent of general trends and determined by the methods of managing the mentally ill.

They point out that during the period covered by their study the ratio of personnel to patients as well as the quality of the staff had remained fairly constant. In further search of factors influencing the decrease in the suicide and escape rates of the Hospital, the authors concluded, after thorough investigation, that age, time of day, time of year, change of personnel, etc., did not account for it. Nor could they find any clue by investigating the number of patients with and without privileges of parole respectively, who attempted, or successfully committed, suicide. While almost half of the total number of patients who committed suicide were on parole at the time, only one of the nine patients who succeeded in suicide during the years 1930 and 1931 was on parole.

On the basis of a careful review of their whole material, the authors draw the conclusion that the improved statistics regarding suicides and escapes must be due to their changed attitude regarding these problems.

One of the most important changes concerns the attitude toward the patients upon their arrival at the hospital. Before 1932, every patient was, upon admittance, placed on active suicide and escape observation. However, since nurses and doctors could not assume that all cases were actually actively suicidal, the responsibility for observation was taken rather lightly and physicians, worried about the care active suicidal cases were going to get, felt compelled to provide them with special nurses. The use of a large part of the nursing personnel in this capacity led on the one hand to a reduction in the number of nurses able to care for the majority of the patients, and on the other hand, on the part of the doubtful patients to the realization that they were considered "suicidal." This situation provided an additional irritating factor and a stimulus to committing suicide. After 1932, all new patients were regarded as being only *potentially* subject to suicide or escape and placed under the casual observation of the whole staff for any indication in their behavior pointing to either suicidal or escape intentions. Consequently, active precautionary measures were taken only in cases which after careful observation were found to be in acute danger of suicide or escape. These measures consisted principally in the thorough but unobtrusive observation by the whole staff. In this way, the responsibility for the prevention of both suicides and escapes was left wholly with the nurses under whose control the patients were all the time.

The authors proceed to point out that serious lack of comfort may prove an additional incitement to a patient's suicidal drive. Such lack of comfort had formerly frequently been caused by the removal of all objects which could be used as instruments in attempts of suicide or escape. It was found that the obvious removal of such objects proved to be more of a stimulant for these attmepts than their presence. The importance of avoiding any situation which the patient may regard as a provocation is stressed. While too much carelessness in attitude may encourage the patient to want to prove the seriousness of his intentions, exaggerated attentiveness may challenge the patient's tendency to opposition. Every problem involving suicide or escape is met with a calm attitude which reassures the patient with regard to his welfare and protection.

In addition, efforts are being made to give every patient as much opportunity for physical activity as possible. Since it was established that patients who attempted suicide or escape in a certain situation would repeat their attempts every time they were exposed to that same situation, particular attention is paid to the avoidance of situations found to act as suicidal stimuli.

During the period under consideration, the following precautionary measures were introduced: 1) All stair wells used by very disturbed patients have been enclosed; 2) waste paper baskets with perforated sides were put in use to prevent their being used as instruments of drowning; 3) a high partition from one of the bathrooms was removed; 4) the height of the walls surrounding the space for out-

door exercise for disturbed male patients was increased.

Another new measure was the assignment of at least one female nurse to every male ward. The patients' tensions were found to be increased in a purely "homosexual" milieu and this measure was a successful step toward relieving them. With the same idea in mind, association between male and female patients at parties and dances was encouraged. They were permitted to dance together and parole patients could meet freely at the tennis courts, library, etc—in short anywhere, where unobtrusive supervision was possible.

While the authors feel that the patients should be given as large a degree of freedom as possible, the goal being to accept "the patient as we find him," they also stress that this can be done only with an adequate protection and must not lead to the point where the patient may do harm to either himself, others, or to property. In accordance with this idea the hospital personnel was educated to assume an attitude of helpfulness and protection and thus replace the "punitive reaction" with regard to restraint, ward changes, seclusion, etc.

In conclusion, the authors reaffirm their opinion that the prevention of suicides and escapes is primarily a nursing problem and that, therefore, the nurses have to be trained accordingly. At the Sheppard and Enoch Pratt Hospital, special lectures are regularly held and the nurses' familiarity with patients plotting either suicide or escape, and with the means that might be used for such attempts is periodically tested. The standard nursing book contains precise information on this subject and a collection of the various utensils instrumental in suicidal attempts is kept on display in the nurses' class room, serving as a constant reminder of the chief hazards. Moreover, every successful attempt at either suicide or escape as well as ways and means to eliminate defaults ni the management are being discussed fully at the usual staff conferences.

As a consequence of this carefull instruction, the nurses are kept acutely aware of the dangers and hazards that may precipitate suicide or escape and are, therefore, less likely to permit the patient to get into a situation that may stimulate his suicidal drive.

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ETIOLOGY OF MENTAL DEFICIENCY. *The Training School Bulletin.* 41:129-137, Nov., 1944.

Many persons have speculated on the origin of Victor of Aveyron. The training of Victor had to provide a progam of education which attempted to restore normal environmental stimulation or that type which attempted to determine the extent to which a defective human organism could attain normal social functioning. Victor, it was found, was feebleminded for his ultimate mental development never exceeded five years of normal growth. Several questions were left unsettled "(a) whether Victor was a child of congenitally normal heritage made defective by early or prolonged environmental deprivation, or (b) whether he was a child of subnormal hereditary endownment, or (c) whether he was a case of secondary (adventitious) mental deficiency. The last probability is perhaps Victor's case."

Recent contributions have indicated the increasing amount of information relative to the fortuitous occurrence of feeblemindedness. Reproductive inefficiency as a cause of non-hereditary feeblemindedness has been investigated. The approaches indicate and confirm the general conviction that feeblemindedness is a condition rather than a disease and in most cases is evident from birth or early age and resultant from ancestral, conceptional, prenatal, natal, or postnatal circumstances. The concept of developmental retardation due to constitutional origins is of first importance. The direction of prevention is the most important factor we can obtain from the studies in the etiology of mental deficiency.

It is necessary to differentiate between the forces of nature and nurture as affecting the physical versus the behavioral aspects of mental deficiency. In the former we have constitutional abnormalities particularly those involving the central nervous system whereas the latter are the inadequates of our social, educational, and occupational areas of adjustment. The behavioral manifestations result "from the subnormal psychological attributes of mental defectives, which in turn derive from their abnormal physical and physiological antecedents. The social representations may be modified within narrow limits through therapy, training, and regimen by inducing more effective expression of constitutional aptitudes than might be obtained with such stimulation and oversight. Under favorable conditions of treatment, education and supervision mental defectives may reach higher levels of attainment and more favorable degrees of adjustment than would be or may have been the case without such measures."

In considering the etiology of mental deficiency, there is a growing tendency to correlate causes with symptoms. A differential diagnosis of mental deficiency as endogenous and exogenous types is weighted with encouraging implications for therapy. Motor and verbal features as revealed in differential diagnosis supply implications for education and training. The main purpose of this paper is to encourage a terminology and a scientifically-sound point of view which offers certain practical advantages. The information can then be used for purposes of diagnosis, prognosis, treatment, care and training.

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THE TRAINING OF MENTALLY DEFICIENTS IN CLASSROOMS. REED M. SMITH. *The Training School Bulletin*, Vineland, N. J., 41:157-160, December, 1944.

Numerous techniques are required to teach mentally deficient children because of their restlessness and short attention span. Standard routine at opening of class, the teacher speaking very slowly using simple words and sentences, the judicious use of silence, and provision for observation are definite aids in their training. Since they learn readily by imitation, the teacher should use subject matter that the children can learn by repetition of either words or actions. Dramatization appeals to both the auditory and visual senses and should be used extensively. Pictures or diagrams can serve where memorization or dramatization cannot be employed.

Characteristically the mentally deficient have little interest in the unfamiliar inasmuch as their imagination is limited. Therefore, all new material must be related to something enjoyable in their background. Much can be related to their life in the institution for they are familiar with the farm, the animals, shops and occupations around them. Considerable repetition is needed as well as the element of surprise to accomplish long-term goals. Immediate rewards, or short-term goals, are important steps in guiding mental defects to long-term educational goals. A chance to sing a song at the end of the class period, a baseball game the next day, or a week-end hike will assure increased effort in the class. Discipline is improved because the less-cooperative pupils can be brought into line by other members of the class. Diversion and manipulation fo the pupil's ego are two further aids to discipline. Drawing attention to other matters and the use of the emotions which make a pupil think better of himself is more useful than those which produce only disappointment and shame. Because of the numerous reminders and experiences of failure in the life of the average mental defective, encouragement of progress regardless of how small it looks to a normal mind and respect for the individual person are essential.

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PSYCHOPATHOLOGICAL DISORDERS IN THE MOTHER. MABEL HUSCHKA. *Journal Nervous Diseases*, 94:76-83, 1941.

This study, based on records of 488 unselected child patients of the New York Hospital and Department of Pediatrics and Psychiatry, Cornell University Medical College, is a strong factual confirmation of what the psychoanalyst learns from the study of his grown-up patients: that the psychopathological disorders of the mother play a very important role in the etiology of maladjustment and psychneurosis of the child.

Only mentally defective children were excluded from this group which does not represent a very underprivileged group. The number of broken homes was small. The psychiatric observations of the mother were based mainly on her reactions in discussing the problems of her child. The author is therefore right in saying that the figure of 41.6 per cent of abnormal mothers is considerably lower than the actual figure. This fact alone illustrates the gravity of the problem involved. As usually the examples of faulty training of children are appalling alike, e.g. the mother who finds it necessary to give the child daily suppositories for 12 months and keeping it on strained foods and wheeling it in a go-cart at the age of five. Only 30 of the mothers were patients of the psychiatric clinic. Twenty-eight of them were psychoneurotics, one was a psychopath and one an epileptic. The treatment (25 cases) was obviously insufficient: 16 received less than 12 hours treatment each. This may account for the poor results: 16 remained unimproved, 8 were improved, one much improved. Twenty-six of the women were severely disturbed in their marital relationship. There has been divorce or separation in 12, 4 more were considering divorce. In only 3 out of 17 cases questioned was the pregnancy wanted. The incidence of rejection of the hostility against the child was very high.

One of the most significant findings is the tendency of the mother to repeat her own problem or pattern in her child. Often the consultation about the child is but a blind for a consultation about the mothers own problems.

Of course, a psychiatric interview with the mother should be mandatory in any case of problem children. This matter should be handled exclusively by psychologists and social workers.

The author realizes well that here lies an important way of prevention of psychoneurosis in adults.

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C - Clinical Psychology

A CRITIQUE OF NON-DIRECTIVE METHODS OF PSYCHOTHERAPY. FREDERICK C. THORNE. *Journal of Abnormal and Social Psychology*. 39:459-471, October 1944.

The author recognizes the development by Rogers of nondirective methods of counseling and therapy as "a new contribution of major significance to the methodology of clinical psychology and psychiatry." He traces the antecedents which led to the theoretical foundations and methods of *nondirective psychotherapy* and their culmination in an internally consistent system with coordinated basic principles. The major part of the paper is devoted to a discussion of the positive factors in non-directive therapy and the inadequacies of this method.

The first positive factor cited is that this new form of therapy emphasizes "client-centered" approaches to the study of personality. The therapist submerges his own emotional needs and intellectual prejudices as completely as possible in the attempt passively to guide the patient by methods of indirection to a more comprehensive self-understanding. The major responsibility for the direction and conduct of psychotherapy is subtly displaced from

the clinician to the patient, who learns to gain insight into life situations and manipulate them actively for himself.

Another point in favor of nondirective therapy is considered by the author to be the way in which it provides for "autonomous regulation of personality." In contrast with such directive techniques as psychoanalysis in which the patient puts himself in the hands of the clinician who actively analyzes, tears down, rebuilds, and resynthesizes the personality, nondirective methods recognize the advantages of allowing the patient to resolve his own problems with a minimum of outside interference. Dr. Thorne feels that it is of great value to assist the client to explore and resolve his own problems personally and autonomously with the clinician minimizing active direction and interfering as little as possible with existing patterns of personality integration.

A third strong point is considered to be the fact that nondirective methods utilize the clinician as a catalyst of growth for which the patient himself is actively responsible. The growth of the patient occurs by resolution of forces from within instead of by reconstruction from without. The therapy is directed toward releasing normal growth potentialities so that the individual gains more control over the forces within himself by acquiring more comprehensive insights.

Two important therapeutic objectives of the nondirective method are considered to be "releasing expression" and "achieving insight." By encouraging free expressions of feeling, mirroring the client's feelings and attitudes, and failing to impose arbitrarily patterns and goals, the clinician provides an ideal situation in which there is the fullest opportunity to ventilate and restructure the feelings and attitudes which have caused maladjustment.

The general principle that therapy proceeds most effectively when the clinician maintains a rigorously detached and objective viewponit and avoids any critical or regulatory action which might stimulate undesirable emotional reactions in the client is supported by nondirective procedures. Thus, objective and impersonal therapeutic relationships are produced and the therapy becomes less complicated and upsetting by "avoiding hostility" and negativism in the patient who senses emotional or critical attitudes in the therapist.

One of the interesting variations of analytic technique is the method of distributive analysis outlined by Diethelm in which the clinician skillfully directs the trends of the patient's associations and productions into areas which seem profitable of exploration. The author believes that there is similar value in the nondirective method of putting subtle pressure on the client to verbalize his own attitudes progressively and thereby to ventilate his feelings under controlled conditions where the therapist skillfully guides the client to better insights. Though skillful questioning, it is possible to implant any desired idea in the client's mind in such a manner that the client thinks he thought of it himself and is therefore more ready to accept it. Also, nondirective methods are very effective in demonstrating inconsistent attitudes, conflicting goals, and disintegrating forces to the client in a painless manner.

Turning to the inadequacies of the nondirective technique of therapy, Dr. Thorne uses as a basis for his criticisms a publication by Snyder of a verbatim recording of what took place in a short-term nondirective treatment of an adult. He points out that "only the barest outline of a case history was obtained" and little attempt was made to secure the background case material which a psychiatrist would consider absolutely essential for even a limited understanding of the total situation. Also, the patient's evaluations of himself have been accepted at face value in Snyder's nondirective treatment. No effort was apparently made to interview the patient's wife or business associates to elicit further evidence from objective sources and to evaluate the situation as a whole. Furthermore, rigid adherence to non-directive techniques, considered essential by Snyder, may prevent the clinician from giving adequate treatment in cases where directive methods would be more effective.

One of the most serious criticisms made by the author against the short-term nondirective treatment is that it never proceeded beyond the most superficial grap-

pling with the patient's problem. The entire treatment limited itself to "surface" phenomena as contrasted with the "depth" analysis which has proved so fruitful in analytic psychiatry. The superficiality of contacts with the patient precluded any comprehensive evaluation of the dynamic mechanisms operant in the total personality. At least six times during the five sessions conducde by Snyder, the therapist, accordng to the author, failed to follow up significant leads which the patient produced spontaneously and seemed anxious to elaborate upon.

The final discussion of non-directive therapy centers around its suitability for various types of patients and as to whether it is to be considered a technique or a system. The author concludes that "there is opportunity for the effective use of many therapeutic methods with numerous variations in technique" and that "our regard should be focused on goals of therapy rather than on dogmatic adherence to specific methodology."

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THE METHOD EMPLOYED TO FORMULATE A COMPLEX STORY FOR THE INDUCTION OF AN EXPERIMENTAL NEUROSIS IN A HYPNOTIC SUBJECT. M. H. ERICKSON. *Journal of Genetic Psychology*. 31:67, 1944.

This is a suggestive piece of work. The causation of neuroses being so little understood, science is grateful for any enlightenment, whether it be from the field of experimental neurosis in animals, or similar methods in man. This article illustrates well the 'devising' or 'inducing' technique for a neurosis, or at least for robot behavior, with vague symptoms simulating that to be met with, clinically, from deep-seated causation. It was attempted by shock methods, (i. e. a shocking suggestion being given the patient). We are not told whether, in fact, any neurotic behavior followed. Rather it is a study in exact methodology, but it is not without significance that the subject was already highly neurotic, (if not laboring under a transference-neurosis in addition) on which the suggestion was planted. It is doubtful whether the experimenter or patient was the more deceived. Consisting essentially of suggesting the theme of Parapraxic Defloration with aggressive intent, (wrought with singular skill), in an oedipal situation, it was elaborated to the sleeping subject, in somewhat over 700 words, many with suggestive double-meaning, the better to reach the unconscious. Its impropriety was successfully shielded from the unconscious by symbolism, i. e. the "shattering of glass by a burning stub" was the essential deed to be recalled. The implanting of such idea in a passive homosexual subject, hypnotized in advance, seems itself an assaultive act of dubious sublimation and veiled in intent, though its meaning was not too apparent. Rationalization of the act, through restitutive compensations of a singular minutial particularity, was attempted; with partial disembarrasing of projection of unconscious wishes, and for subsequent reprieve in the eyes of science, that argues a strong paranoid obsessive bias. The fuller documentary evidence serves to confirm this. It should be read in its entirety. We feel that attention should be drawn to these tendency forming experiments, and the need to hypnotize others, for which the public had always, for some reason, a profound mistrust, that may bring discredit on a worthy scientific discipline.

The complex story of the title becomes "a complex" (meaning unexplained) within the body of the article; whilst some sympathy is assumed in the reader for the values of the hynotic approach, and the uses of the transference exploitation in particular; and for its attempt at "influence," otherwise its charlatonism may become too palpably obvious. Finally no hint is given as to what neurosis (if any) followed this curious means, or as to pathologic behaviors (to be expected); though there is a last moment revelation (as if by accident) that the subject let his ash fall into his trouser-cuff (parapraxis) and called it premature ejaculation. He seems the same subject of the 1935 experiments; the transference is long.

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D - Psychotherapy

COMBINED CONVULSIVE THERAPY AND PSYCHOTHERAPY OF THE NEUROSES. J. D. MORIARY AND A. A. WEIL. *Archives of Neurology and Psychiatry*, 50:685-690, Dec., 1943.

In this article the authors present a study of 20 patients from the New Hampshire State Hospital suffering from various forms of neuroses treated by both psychotherapy and convulsive treatment. They tabulate their results. They report that from a comprehensive survey of the lierature concerning convulsive therapy of nueroses, the results of 15 authors, representing a total of 130 patients, are as follows:

In 36 patients (28%), the disease was described as cured or in remission. In 80 patients (64%), the conditions was reported as improved, and in only 14% were the conditions not improved, or results questionable. In the literature they also report that there were a number of poorly defined disorders designated as depression or depressed-obsessive states and chronic tension states. These were not included in the percentages, although they paralleled the general pattern of results. Most authors dealt primarily with psychotic patients and gave the results for neurotic patients as an appendix. Psychotherapy was used only in conjunction with shock treatment. The opinion of two authors was that probing psychotherapy might be harmful. When Metrazol was used, convulsive treatment was considered to be too drastic for neuroses, but it was felt that electric shock therapy could be administered with no major risks, and a few minor ones, and that it was practicable for the out-patient service. The type of implement used is fully described by Freedman. The important therapeutic principle is the production of a quick convulsion with a minimal amount of current. From the survey of the literature the two striking conclusions drawn are: (1) The results of various convulsive treatments of the neuroses are encouraging; they are even better than for most of the major psychoses; and (2) most investigators used shock treatment for neuroses only grudgingly, and resorted to it only with patients who manifested stubborn or chronic conditions.

The study was primarily undertaken to evolve a practical method, rather than to make a statistical comparison of different types of treatment. The usual procedure of choice was first analytic psychotherapy, followed by four or six electric shock treatments, and finally by efforts of re-education. Their results were as follows:

Out of a total of 20 patients, in 10 (50%) the condition was considered to be in remission; in 9 (45%) the condition was considered to be much improved, or improved, and in 1 (5%), the condition was considerably improved. All patients with remissions have made a satisfactory adjustment since leaving the hsopital. None of the group remained in the hospital.

The authors compared their results also with a controlled study of 46 neurotic women and 33 neurotic men admitted to the hospital during a seven-year period from 1934-1941. These patients received orthodox treatment for neuroses, including psychotherapy, but no shock treatment. Seven percent were recovered or discharge, 71% were much improved, or improved, and 22% not improved. They describe three cases (hysteria, psychoasthenia, and psychoneurosis, mixed type) and report their results with these. With psychotherapy alone, the average length of hospitalization was 8½ months for the men and 9 months for the women. With combined psychotherapy and shock treatment, none needed to remain in the hospital more than eight weeks after the first shock treatment. With shock therapy alone the patient showed immediate improvement in eating and sleeping, followed by an improvement in emotional tone.

Clark and Norbury tend to support the premise that in general shock therapy achieves results by stimulating the most basic drives for self-preservation. It is also possible that the improvement is brought about through the medium of cortical stimulation. It is not certain how shock therapy accomplished its results.

The conclusion of the authors is that while shock therapy prepares the ground for psychotherapy by improving affective tone, fostering active cooperation, and tending to overcome "repetition compulsion," psychotherapy itself permits the patient to gain understanding and inner strength guarding against relapse.

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Disintegration and Restoration of Optic Recognition in Visual Agnosis. Alexandra Adler. *Archives of Neurology and Psychiatry.* 51:243-259, March 1944

The author presents a case of visual agnosia in a woman, 22 years old, who was a victim of the Cocoanut Grove Night Club fire in Boston, November, 1942. Adler gives a detailed description and analysis of the patient's symptoms and the course of the illness from the onset until the condition became stationary. The patient is one of two persons who recovered from permanent lesions of the brain, most probably due to carbon monoxide posioning experienced during the fire disaster. The chief disturbance consists mainly in the patient's inability to perceive the whole—The *Gestalt*—visually, since only parts of the whole are perceived. Their correct relation is not recognized, resulting in an inability to read and copy letters and geometric figures, and to recognize figure or objects on short exposure. Her writing was also impaired. Examples of the perceptual impairment are given in reproductions of the patient's handwriting during the different states of her illness.

Electro-encephalographic examinations done three weeks after the injury, and again four months later revealed: "very low voltage record, no build-up with over ventilation, no slowing and no definite focus of abnormal activity. No marked difference was noted between the first and second encephalogram."

Due to the patient's intelligence and insight ino her disability, it was possible to identify additional disturbance in the nature of perserveration of visual attention and optic impressions. Preceding optic impressions superimposed themselves on subsequent ones, thus interfering with proper perception and recognition of the object. This symptom is in the same category as perserveration in speech and writing. The patient's agnosia, according to Lissauer's first description, belongs to the "apperceptive" type of visual agnosia. The identity of the mechanism exhibited by this patient in each of the disorders of visual performances makes it unlikely that the visual symptoms of opic agnosia have a separate localizing significance.

The patient presenting these symptoms is likely to forget and distort what she has learned, therefore compensatory efforts to build up visual recognition should be encouraged.

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E - Medical & Biology

Psychogenic Rheumatism. E. W. Boland and Col. W. P. Corr. *Journal American Medical Association.* 123:805, 143.

Out of 450 consecutive admissions to and Army General Hospital for arthritis and allied conditions the authors made the diagnosis of purely psychogenic rheumatism in 22.3 per cent of peripheral joint complaints and in 17.7% of back complaints. The cases included cases of subjective complaints without or with inadequate structural changes in the musculoskeletal system.

The term "psychogenic rheumatism" as used by the authors is not very fortunately chosen. The authors "hold no brief for the concept that organic joint disease may result from psychic conflicts" or "that mental factors are etiologically related to inflammatory joint disease." Therefore the least the authors could have done would have been to call it "pseudo-rheumatism."

Other interesting facts are: 5.9% of

the peripheral joints group and 25.4% of the "back complaints" group had psychogenic symptoms superimposed upon true rheumatism. The average military service was about nine months, and over one third of this time was spent in army hospitals. The sedimentation rate was normal. There was no relation to age, rank, previous occupation, intelligence or education. Seventy-six per cent gave a history of symptoms prior to military service and one half of those dated their disability to an injury. One third gave a history of invalidism due to arthritis in the family. Back and lower extremities were the most frequently affected parts probably because of their relation to lomocotion which is essential in military service.

In connection with this the authors quote Strecker who places the frequency of musculoskeletal functional disorders last in the list of organs while Haliday in compensation cases found psychogenic factors in 37 per cent of cases labeled rheumatism. In both the military as well as compensation cases a disease of the locomotor system solves an emotional conflict. The diagnosis of "psychogenic rheumatism" is facilitated by (1) gross incongruities between symptoms and structural changes, (2) persistence of disability, (3) functional characteristics of the complaints, (4) bizarre postures or limps and (5) the association of other psychoneurotic manifestations.

In the light of their experience the authors question English reports about the frequency of "fibrositis" in rheumatic cases in the army which is given as about 70 per cent. In their own cases only 5.8 per cent were classified as fibrositis. The attempts to return the cases of psychogenic rheumatism to full or limited duty proved largely unsuccessful. As internists the authors do not discuss in any detail the methods used. They express hope that prompt recognition and "proper" psychotherapy will prevent some of these cases from developing.

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